

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05046  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                       |  |
|--|--|---|---|---|-----------------------|--|
| 1. DECEASED NAME<br>(Type of page) 07<br>FIRST MIDDLE LAST<br>Leoda Pauline Abbott   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 8 87                         |   | 2b. HOUR<br>4:55 A.M. |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 23, 1914   |                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                       |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.   |   |   |                       |  |
| 10. CITY OR TOWN OF DEATH<br>Jefferson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4753 Old Middletown Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook                        |                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant  |  |   |   |   |                       |  |
| 13a. STATE<br>Maryland   |  |   |   |   |                       |  |
| 13b. CITY OR TOWN<br>Frederick   |  | 13c. CITY OR TOWN<br>Jefferson  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       |  |
| 13e. STREET ADDRESS / ZIP CODE<br>4753 Old Middletown Rd. / 21755  |  |   |   |   |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Thomas Sweeney   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Pauline Holmes |   |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-34-3973  |   | 17. INFORMANT<br>ADDRESS<br>Route 2, Box 228A<br>Essie A. Moler - Knoxville, Md. 21758          |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 YEAR</u> |  |   |   |   |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |   |                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> , 19 <u>79</u> , to <u>2/8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                       |  |
| 22b. SIGNATURE<br><u>W. H. Hagan</u>   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>2/8/87  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>WATNE Hagan</u>  |  | 22e. ADDRESS<br><u>Brownsville, Md. 21716</u>   |   |   |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/11/87  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Old Brethren Cem.   |                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brownsville, Washington, Md.   |  |   |   |   |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert L. Spencer - Harpers Ferry, WV 25425  |  | ADDRESS<br>P. O. Drawer C   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1987   |                       |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>W. H. Hagan</u>   |  |   |   |   |                       |  |

MEDICAL CERTIFICATION

20% COTTON FIBER

MADE IN U.S.A.



FEB 9 1954

044288 FEB 17

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05047  
REG. NO.

|   |                         |  |   |   |  |   |   |  |
|---|-------------------------|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George Hume ANDERSON</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2 4 19 87</b> |   |  | 2b. HOUR<br><b>6A</b>   |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 15, 1927</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60 YRS.</b>   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br><b>February 4, 19 87</b>                             | 2d. HOUR<br><b>6A</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD.                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Factory</b> |  |
| 13a. STATE<br><b>Maryland</b>   |                         |  |   | 13b. CITY OR TOWN<br><b>Frederick</b>   | 13c. CITY OR TOWN<br><b>Pt. of Rocks</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence D. Anderson</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lilly McCutcheon</b>  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1945-1946</b>  |   | 17. INFORMANT<br><b>Mrs. Lillian Anderson</b><br><b>3837 Clay St., Pt. of Rocks, Md. 21707</b>  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |                         |  |   |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Robert J. Thomas</b>   |                         | M.D. <b>Deputy</b>   |   | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>2/5/87</b><br><b>21701</b>  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Dr. Robert J. Thomas</b>  |                         | ADDRESS<br><b>812 Toll House Ave., Frederick, Md.</b>  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>Feb. 7, 1987</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul's Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pt. of Rocks, Frederick, Md.</b>               |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Smith, Keeney &amp; Basford Funeral Home</b>   |                         |  |   | DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John K. ...</b>  |   |  |
| 106 East Church St., Frederick, Md. 21701   |                         |  |   | FEB 09 1987   |  |   |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87-05048  
REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Sydney</b> <b>Arthur</b> <b>ASDELL</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2</b> <b>21</b> <b>87</b>   |  | 7b. HOUR <b>1540M</b>   |   |
| 3 SEX <b>Male</b>   | 4 RACE <b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 23, 1897</b>  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>                             |   |   |
| 10 CITY OR TOWN OF DEATH <b>Frederick</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Professor</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>College</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |  |   |   |
| 13a. STATE <b>Maryland</b>  | 13b. COUNTY <b>Frederick</b>  | 13c. CITY OR TOWN <b>Frederick</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <b>5719 Jefferson Blvd. 21701</b>                  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John Asdell</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amy Love</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO. <b>052-32-7825</b>   |  | 17. INFORMANT ADDRESS <b>Philip Tregarthen Asdell, Item 13</b>                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>Perkman's Disease</b>   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>2/14/87</b> , 19____, to <b>2/21/87</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/21/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |   |   |  |   |   |
| 22b. SIGNATURE <b>Austin Pearre, Jr.</b>  |   | DEGREE  |  | 22c. DATE SIGNED <b>2/21/87</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Austin Pearre, Jr., M.D.</b>   |   | 22e. ADDRESS <b>804 Toll House Ave., Frederick, Md.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  | 23b. DATE <b>Feb. 23, 1987</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>                           |   |   |
| 24. FUNERAL DIRECTOR <b>Olin L. Molesworth, P.A., Damascus, Md.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1987</b>   |   |   |
|   |   |   | 25b. REGISTRAR'S SIGNATURE   |   |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, accident, traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA (5, 4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05049

REG. NO.

|   |  |  |   |  |                                   |  |   |
|---|--|--|---|--|-----------------------------------|--|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | MONTH  | DAY                               | YEAR   | 2b. HOUR  |
| 17 DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |   | MIDDLE   | LAST                              | 2b. HOUR   |   |
| William Howard Baker  |  | 2  |   | 23   | 87                                | 1725 M   |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | IF UNDER 1 YEAR  |   |
| Male  | White  | MONTH DAY YEAR   |   | 77 YRS   |                                   | IF UNDER 24 HRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |
| Virginia  | U.S. / Frederick   |  |   | Frederick  |                                   | MD   |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |
| Frederick   | Frederick Memorial Hospital  |  | Railroad  |  | Railroad                          |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |                                   |  |   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?                                      |  | 13e. STREET ADDRESS / ZIP CODE    |  |   |
| Maryland  | Frederick  | Knoxville  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | P.O. box 172 21758                |  |   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   | ADDRESS  |                                   |  |   |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |   |  |                                   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   |  |   |
| No  |  | 229-05-0182  |   |  |                                   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Intracranial hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Intracerebral aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>13 days<br>10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Pneumonia   |  |  |   |  |                                   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/22, 19 75, to 2/23, 19 87, that (1) (we) lost saw the deceased alive on 2/23, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |  |   |  |                                   |  |   |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |  |   |
| Kathleen Woods Stern MD   |  |  |   | 2/24/87  |                                   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |                                   |  |   |
| Kathleen Woods Stern MD   |  | 6010 Ninth Ave, Brunswick, Md 21716  |   |  |                                   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |   |
| Removal   |  | 2-24-87  |   |  |                                   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |   |
| State Anatomy Board   |  |  |   | Balto., Md.  |                                   | FEB 27 1987 Julia Landon-Budnick                               |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove a copy of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. (If item 21 is marked on item 18, the medical examiner must be notified of change.)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 05050   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 7a. DATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Renneberger BALDWIN   |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR February 14, 1987   |  |
| 3. SEX Female   |  |  |  |  |  |  |  |  |  | 7b. HOUR 3:00 P.M.   |  |
| 4. RACE White   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1907  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.   |  |
| 10. CITY OR TOWN OF DEATH Frederick   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY Home   |  |
| 13a. STATE Maryland   |  |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN Frederick  |  |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 13d. STREET ADDRESS / ZIP CODE 6900 Trout Drive, 21701   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Luther Alonza Renneberger   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Hickman  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 577-24-2701   |  |
| 17. INFORMANT ADDRESS Mrs. Margaret B. Wightman, Frederick, Md. 6900 Trout Drive  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 701   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASAC<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. Poisoning Dis. essential hypertension   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-3, 1987, to 2-14, 1987, that (I) (we) lost saw the deceased alive on 11-26, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Dr. Thomas E. Stone, M.D. DEGREE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 2-17-87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas E. Stone, M.D.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 4 West Third Street, Frederick, Md. 21701   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE Feb 18, 1987   |  |
| 23c. NAME OF CEMETERY OR CREMATORY Linden Hills Cemetery  |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.  |  |
| 24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 20 1987 Julia Tinson-Randall  |  |
| 106 East Church Street, Frederick, Md. 21701  |  |  |  |  |  |  |  |  |  |  |  |

BP

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Theresa D. ...

12-11-77

11-11-77

FEB 80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR1- DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Mary

Elizabeth

BALL

2a DATE OF DEATH MONTH DAY YEAR  
February 23, 1987

2b HOUR

8: 00<sup>M</sup>

3. SEX

Female

4 RACE

White

5. DATE OF BIRTH

Aug. 27, 1898<sup>YEAR</sup>

6 AGE (IN YEARS LAST BIRTHDAY)

88 yrs.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

West Virginia

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Frederick County, MD.

10 CITY OR TOWN OF DEATH

Frederick

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Citizens Nursing Home

12a USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b KIND OF BUSINESS OR INDUSTRY

Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE  
Maryland13b COUNTY  
Frederick13c CITY OR TOWN  
Frederick13d INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

Rosemont Ave. Ext., 21701

14 FATHER'S NAME

William

MIDDLE

Anthony

15 MOTHER'S MAIDEN NAME

Margaret

MIDDLE

McKinstry

16a WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

213-74-5147

17 INFORMANT

ADDRESS

Mrs. Elizabeth Myers, 750 Green Valley Road  
New Windsor, Md. 2177618 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Renal failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

ASCVD. c Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHITE ☐ NOT WHITE ☐  
AT WORK ☐ AT WORK ☐22a I certify that (I) (this hospital) attended the deceased from Feb 1, 1985, to Feb 23, 1987, that (I) (we) lost  
saw the deceased alive on Feb 23, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) (did not) view the body after death.

22b SIGNATURE

B. O. Thomas, Jr.

DEGREE

MD

ATTENDING  
PHYSICIANMEDICAL  
DIRECTOR ☒STAFF  
PHYSICIAN ☐

22c DATE SIGNED

2/25/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. B. O. Thomas, Jr., M.D.

22e ADDRESS

Professional Building, Frederick, Md. 21701

23a BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b DATE

Feb. 25, 1987

23c NAME OF CEMETERY OR CREMATORY

Mt. View Cemetery

23d LOCATION

CITY OR TOWN

Union Bridge, Carroll, Maryland

24 FUNERAL DIRECTOR

Smith, Keeney and Basford Funeral Home

106 East Church Street, Frederick, Md. 21701

25a DATE REC'D. BY REGISTRAR

FEB 26 1987

25b REGISTRAR'S SIGNATURE

Julia Frederick (Rudolph)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical probe performed.

1- FOR STATE REGISTRAR Janice

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05052

|   |  |   |   |  |                            |  |
|---|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JANICE Robinson Bowels</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/26/87</b> |  | 2b. HOUR<br><b>4:15 AM</b> |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 11, 1916</b>  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD                                      |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   |  |                            |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Frederick</b>   |   | 13c. CITY OR TOWN<br><b>Frederick</b>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Edward Robinson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice M. Creager</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <b>XX</b> NO <input type="checkbox"/>                                  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-10-5094</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Raymond E. Bowels, Jr.<br/>210 East Eighth St., Frederick, Md. 21701</b> |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARDS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b> |  |   |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Colon Cancer, Malnutrition</b>   |  |   |   |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                         |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |  |   |   |  |                            |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>Allen J. Gilson</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/26/87</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen J. Gilson</b>   |  | 22e. ADDRESS<br><b>1475 TANCY Ave Fred MD</b>   |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 28, 1987</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>                                     |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>  |  |   |   |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Richard Smith</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 02 1987</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John William Rader</b>  |                            |  |
| 106 East Church St., Frederick, Md. 21701   |  |   |   |  |                            |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

09053

|  |  |  |  |   |  |   |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Leonard Clark Boyer</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb 13 1987</b>              |   |  | 2b. HOUR<br><b>8:30</b><br>A. M.  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 15 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b><br>YRS MONTHS DAYS                                 |  | 6. IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co.</b> MD.                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middletown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2536 Sumantown Rd.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>farmer</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>farm owner</b>   |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Fred.</b>  |  | 13c. CITY OR TOWN<br><b>Middletown</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2536 Sumantown Rd. 21769</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eldridge Clark Boyer</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Mae Biser</b>  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-36-6773</b>  |  | 17. INFORMANT ADDRESS<br><b>Evelyn Boyer Middletown, Md. 21769</b>                              |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Disease with healed inferior</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>myocardial infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 years</b> |  |  |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.   |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>1/24</b> 19 <b>80</b> , to <b>2/13</b> 19 <b>87</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>2/15</b> 19 <b>87</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Henry V. Chase MD</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED<br><b>2/14/87</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henry V. Chase</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>804 Toll House Ave Frederick MD</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Feb. 16, 1987</b>                                      |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lutheran Cemetery</b>                                  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Jefferson Fred. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Thompson Funeral Home Middletown, Md.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 20 1987</b>   |  |  |  |  |
|  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swinton-Randall</b>                                      |  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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POETS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05054  
REG. NO.

|   |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY<br>MIDDLE ELLEN<br>LAST BREIGHNER   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 06 87                        |  |   | 2b. HOUR<br>0521 M   |   |  |   |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>CAUCASIAN<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>02 26 02  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick, MD                                 |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>None  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland   |  |  | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Frederick  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>822 North Market Street/21701 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Lee Hargett  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jessie Matilda Johnson  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-10-2197 |  | 17 INFORMANT<br>ADDRESS<br>P.O. BOX 126<br>Mrs. Barbara Hiltner Pt. of Rocks, Md. 21777 |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF (c) ENTERIC FISTULA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25, 1987, to 2/3, 1987, that (I) (we) last saw the deceased alive on 2/3, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>John Vitarello M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   |  |   | 22c. DATE SIGNED<br>Feb. 06, 1987  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Vitarello, M.D.   |  |  |  | 22e. ADDRESS<br>Frederick, Maryland 21701  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2/10/1987   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>R.E. DAILEY & SON, PA   |  |  |  | 1201 N. Market Street<br>Frederick, Md. 21701  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 15 1987   |   | 25b. REGISTRAR'S SIGNATURE<br>John Gordon Radner   |   |  |

2025 COLLECTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please insert carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

67 05055

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |                             |  |
|--|--|---|--|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VERNON MASON BRIGGS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 5, 1987</b> |   | 2b. HOUR<br><b>10:50P</b> M |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 6, 1908</b>                               |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  | 8. YRS.   |                             |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>District of Columbia</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick,</b> MD.                              |                             |  |
| 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Real Estate</b>  |                             |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>Maryland</b>   |  | 15b. COUNTY<br><b>Frederick</b>   |  | 15c. CITY OR TOWN<br><b>Frederick</b>   |                             |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edson W. Briggs</b>   |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Pyles</b>  |  | 18. STREET ADDRESS / ZIP CODE<br><b>121 Kline Boulevard 21701</b>                           |                             |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 20. SOCIAL SECURITY NO.<br><b>579-07-5611</b>   |  | 21. INFORMANT<br><b>Mr. Donald Briggs</b>   |                             |  |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal Bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |  |   |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>hip fracture, R hemiparesis 20 CVA</b>  |  |   |  |   |                             |  |
| 24. DATE OF OPERATION<br><b>2/5/87</b>   |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>hip fracture</b>  |  | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |                             |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:5- 19 87</b>   |  | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>2/5</b> |                             |  |
| 30. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME   |  | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>5-5</b>   |  | 32. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>87 215 87 0</b>                      |                             |  |
| 33. I certify that (I) (this hospital) attended the deceased from <b>2/5</b> 19 <b>87</b> to <b>2/5</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)      |  |   |  |   |                             |  |
| 34. SIGNATURE<br><b>Casper E. Cline, III MD PA</b>   |  | 35. DEGREE<br><b>MD</b>   |  | 36. DATE SIGNED<br><b>2/5/87</b>  |                             |  |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Casper E. Cline, III MD PA</b>  |  | 38. ADDRESS<br><b>804 Toll House Ave. Frederick, Md 21701</b>   |  |   |                             |  |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 40. DATE<br><b>2/9/87</b>   |  | 41. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                            |                             |  |
| 42. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Prince George, Md.</b>  |  | 43. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1987</b>  |  | 44. REGISTRAR'S SIGNATURE<br><b>John J. Anderson, Registrar</b>                             |                             |  |

BP

CHIEF

RECEIVED

NEW YORK



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043770 FEB 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

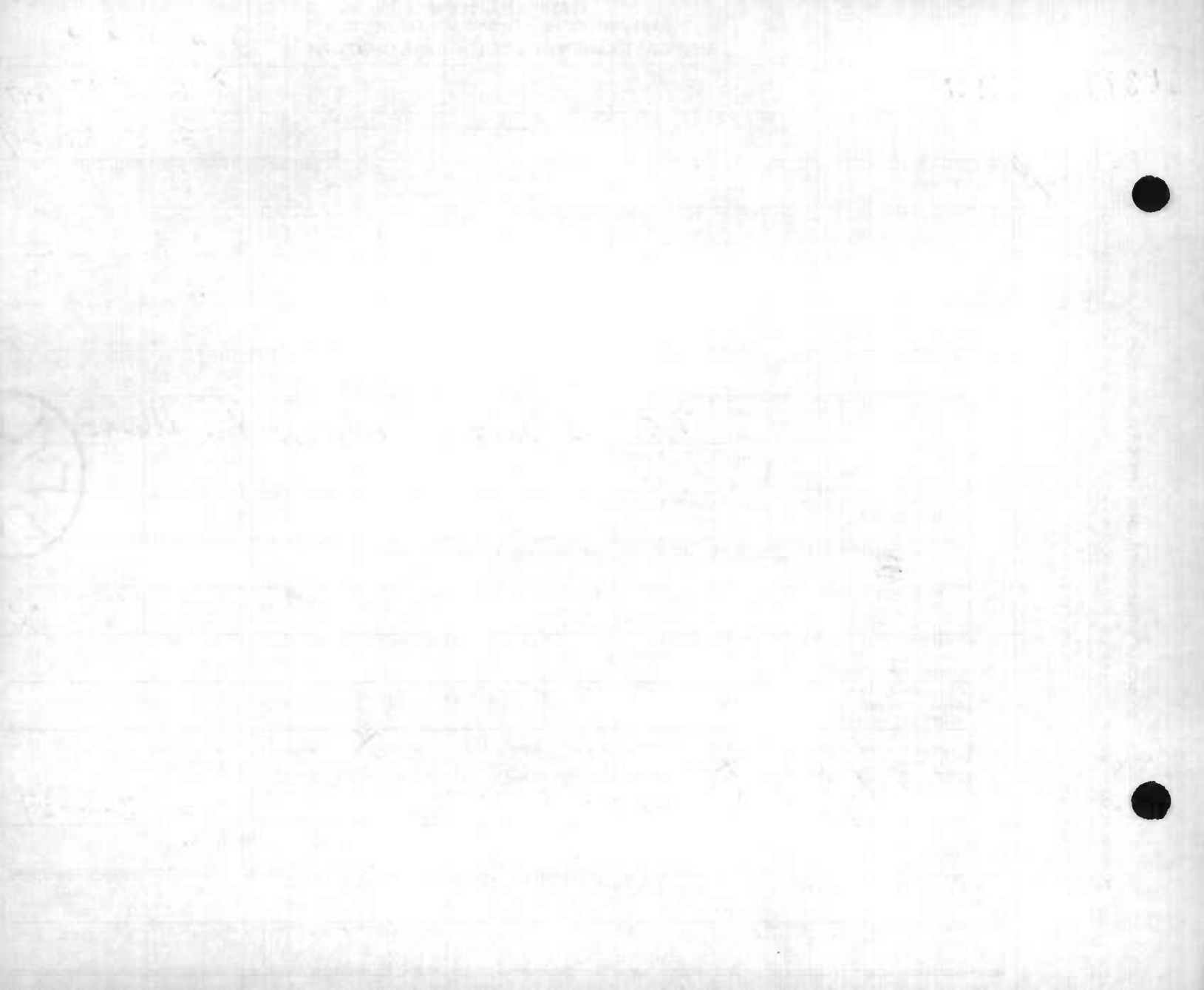
REG. NO. 05050

|   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
|---|-----------|--|---|---|------|---|------|---|--|-----------------------|--|----------|--|
| 1. FOR STATE REGISTRAR  |           | 2a. DATE KNOWN OF DEATH                                  |   |   |      |   |      |   |  |                       |  | 2b. HOUR |  |
| 1. DECEASED NAME  |           | 2a. DATE KNOWN OF DEATH                                  |   |   |      |   |      |   |  |                       |  | 2b. HOUR |  |
| FIRST MARGARET  |           | MONTH DAY YEAR 2 5 87                                    |   |   |      |   |      |   |  |                       |  | 1647     |  |
| LAST CARITHERS  |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  |      | IF UNDER 24 HRS.  |      | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR              |  |          |  |
| MALE  | WHITE     | MONTH DAY YEAR 06 21 18                                  | 68 YRS.   | MONTHS  | DAYS | HOURS   | MIN. | MONTH DAY YEAR 2 5 87   |  | 1647                  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |           | 7b. CITIZEN OF WHAT COUNTRY?                             |   | 8. MARRIED  |      | NEVER MARRIED   |      | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                       |  |          |  |
| SC  |           | USA  |   | WIDOWED   |      | DIVORCED  |      | FREDERICK MD.   |  |                       |  |          |  |
| 10. CITY OR TOWN OF DEATH   |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   |   |      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |      | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                       |  |          |  |
| FREDERICK   |           | FREDERICK MEMORIAL HOSPITAL                              |   |   |      | HOMEMAKER   |      |   |  |                       |  |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| 13a. STATE  | 13b. CITY | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |      |   |      |   |  |                       |  |          |  |
| MD  | FREDERICK | FREDERICK  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1421 Taney Ave., 21701                                      |      |   |      |   |  |                       |  |          |  |
| 14. FATHER'S NAME   |           |  |   | 15. MOTHER'S MAIDEN NAME                                    |      |   |      |   |  |                       |  |          |  |
| FIRST MIDDLE LAST HARRY BARNUM  |           |  |   | FIRST MIDDLE LAST HASTY GRAHAM                              |      |   |      |   |  |                       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |           |  |   | 16b. SOCIAL SECURITY NO.                                    |      |   |      | 17. INFORMANT ADDRESS   |  |                       |  |          |  |
| NO  |           |  |   | 247-03-7497   |      |   |      | Linda Lochstampfor 1773 Harvest Dr. Frederick, MD                             |  |                       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| PART I DEATH WAS CAUSED BY:   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i>  |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| (c)   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
|   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| 19a. DATE OF OPERATION  |           |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |      |   |      | 20. AUTOPSY?  |  |                       |  |          |  |
|   |           |  |   |   |      |   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                       |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |           |  |   | 21b. TIME OF INJURY   |      |   |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                       |  |          |  |
|   |           |  |   | HOUR A.M. MONTH DAY YEAR                                    |      |   |      |   |  |                       |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |           |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |      |   |      | 21f. LOCATION   |  |                       |  |          |  |
|   |           |  |   |   |      |   |      | CITY OR TOWN COUNTY STATE   |  |                       |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulting from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| ACTUAL SIGNATURE <i>Robert J. Thomas</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 2-6-87  |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| EXAMINER'S NAME Robert J. Thomas, M.D. ADDRESS 812 Toll House Ave. Frederick, Md. 21701   |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |           |  |   | 23b. DATE   |      | 23c. NAME OF CEMETERY OR CREMATORY                            |      |   |  | 23d. LOCATION         |  |          |  |
| BURIAL  |           |  |   | 2/9/87  |      | Brown's Cemetery  |      |   |  | Foxville Frederick MD |  |          |  |
| 24. FUNERAL DIRECTOR G. DOUGLAS STAUFFER NAME ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701  |           |  |   |   |      |   |      |   |  |                       |  |          |  |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>John Henderson-Randall</i>  |           |  |   |   |      |   |      |   |  |                       |  |          |  |

07/84  
25M

BP  
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(VR A15 ME (5))

FEB 10 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 87 05051  |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRISON LINCOLN CARTER</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2 18 87</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 18 1926</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b><br>YRS. MONTHS DAYS                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>FREDERICK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5600 FRANCO PLACE</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK MD.</b>                                    |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>FREDERICK</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES B CARTER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY ALICE LOONEY</b>   |  | 13d. STREET ADDRESS<br><b>5600 FRANCO PLACE</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-22-0600</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JOHN M. CARTER KEYMAR MD.</b>                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL METASTATIC CANCER OF TONGUE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12</b> 19 <b>86</b> , to <b>2-8</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2-14</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                    |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Arthur G. Mantel</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>2/12/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR G. MANTEL M.D.</b>  |  | 22e. ADDRESS<br><b>11801 FINGERBOARD RD. MONTPELIER, MD 21790</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>2-14-1987</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RESTHAVEN</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. CHILTON</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FREDERICK FREDERICK MD</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1987</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |   |  |



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return it to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 05058  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HELEN CATHERINE CHAPMAN   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02/20/87  |  |   |  | 2b. HOUR<br>9:44 AM   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 14 1910  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7b. IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>FREDERICK MD   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>IJAMSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2308 Oak Drive, |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |  |  |   |  | 13b. COUNTY<br>FREDERICK   |  | 13c. CITY OR TOWN<br>IJAMSVILLE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RAY E. TRUXELL   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORENCE KIRK   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>Marilyn Chapman  |  | ADDRESS<br>MD 21754<br>2308 Oak Drive, Ijamsville,   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>extensive pancreatic</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cholesterol with</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>hepatic failure</u>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 mo   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> 19 <u>85</u> to <u>2/20</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>P. Gregory Rausch</u>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>2/20/87</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. GREGORY RAUSCH   |  |  |  |   |  | 22e. ADDRESS<br>4 West 7th St., Suite Frederick, MD 21701  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>2/23/87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>RESTHAVEN CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FREDERICK FREDERICK MD   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1987  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. DOUGLAS STAUFFER<br>1621 Opossumtown Pike, Frederick, MD  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Benton-Randall</u>  |  |   |  |   |  |

FEB 24 1961

RECEIVED

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W. A. S.

10/1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8705059

| FOR<br>1. STATE<br>REGISTRAR   |  |   |  | REG. NO.   |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>AUBREY ALBERT CLAGGETT, SR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02 08 1987</b>                                   |  | 2b. HOUR<br><b>2:20 PM</b>  |
| 3 SEX<br><b>MALE</b>   | 4 RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 27 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS                               |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK</b> MD.                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>FREDERICK</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7105 Fish Hatchery Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GROUND'S KEEPER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REC.</b>  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. CITY OR TOWN<br><b>FREDERICK</b>  | 13c. CITY OR TOWN<br><b>FREDERICK</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GRAFTON RICHARD CLAGGETT</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>OLIVE BEATRICE CLARY</b>               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-30-7719</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Frederick, MD</b>                               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. That (I) (we) last saw the deceased alive on <b>JAN 7</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |  |   |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |  | 22c. DATE SIGNED<br><b>2/1/87</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PICKERS</b>  |  |   |  | 22e. ADDRESS<br><b>Thermans Md 21788</b>                                       |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/12/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven Mem. Gardens</b>            |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick MD</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1987</b>   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>G. DOUGLAS STAUFFER<br/>1621 Opossumtown Pike, Frederick, MD 21701</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                               |   |

100% COW 11958

2000

11/10/00



4 5 4 6 9 FEB 27 87

#1, per F.H. 2/24/87 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 0 5 0 6 0  
REG. NO.

|  |  |  |  |   |                               |  |  |
|--|--|--|--|---|-------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Cora Lorraine Clary</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Feb. 18, 1987</b> |   | 2b. HOUR P.<br><b>7:32 M.</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 25, 1926</b>   |                               | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>60 YRS 11 23</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co., MD</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Airy</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>107 Sycamore Road</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Postmistress</b>  |                               | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Frederick</b>   |                               | 13c. CITY OR TOWN<br><b>Mt. Airy</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lee Levi Condon</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bessie May Barth</b>   |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-3308</b>   |  | 17. INFORMANT ADDRESS<br><b>Robert M. Clary, Same as # 13</b>   |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic Colon Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |                               |  |  |
| 9a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                               |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-4-87</b> to <b>2-18-87</b> , that (I) (we) last saw the deceased <b>2-4-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not see the body after death, so state.)  |  |  |  |   |                               |  |  |
| 22b. SIGNATURE <i>[Signature]</i>  |  |  |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                               | 22c. DATE SIGNED<br><b>2-19-87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-21-1987</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prospect</b>   |                               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Mt. Airy, Frederick, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Charles W. Burrier, Jr., Sykesville, Md.</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR <b>FEB 24 1987</b> REGISTRAR'S SIGNATURE <i>[Signature]</i>  |                               |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low required death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The detached page 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 05061   |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred Porter Cleaves   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 20 87                                 |  | 2b. HOUR<br>5:40 PM  |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 14, 1920  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Texas  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.                          |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lung Assoc.                                     |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Fred.   | 13c. CITY OR TOWN<br>Frederick   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert - Porter   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice - McGee  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>122-09-1843   |  | 17. INFORMANT<br>ADDRESS<br>Bertram J. Cleaves, Braddock Heights, Md.                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) TERMINAL CANCER OF THE PANCREAS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11, 19 86, to 2-20, 19 87, that (I) (we) lost saw the deceased alive on 2-20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br>Arthur G. Haxel, M.D.   |  | DEGREE  |  | 22c. DATE SIGNED<br>2/20/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARTHUR G. HAXEL, M.D.  |  | 22e. ADDRESS<br>187 Thomas Johnson Drive, Frederick Md. 21701   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   | 23b. DATE<br>Feb. 21, 1987   | 23c. NAME OF CEMETERY OR CREMATORY<br>Smithsburg Crematory  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Smithsburg, Wash., Md.           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Davis Funeral Home, Smithsburg, Md., 21783  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 02 1987  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Lindner                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low required for death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate remains a carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 67 05002   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  | 1. DECEASED NAME FIRST MIDDLE LAST<br>Orpha Ruth Coblentz   |  |   |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan. 29, 1987   |  |  |  | 2b. HOUR<br>12:30 P M   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 28, 1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Homewood Retirement Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>clerk  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>retail   |  |
| 13a. STATE Md. 13b. COUNTY Fred. 13c. CITY OR TOWN Frederick  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>10 Linden Ave. 21701  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br>Charles William Ahalt  |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br>Pearl Mae Boyer   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>215-26-1473  |  | 17. INFORMANT ADDRESS<br>Dennis Ahalt Mt. Airy, Md.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Renal Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Pneumonia - Diabetes - Aortic Stenosis |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from many years, 19 to 1/29/87, 19, that I (we) lost saw the deceased alive on 1/29/87, 19, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Antia Perry   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>2/5/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 31, 1987   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Reformed Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Middletown Fred. md.   |  |
| 24. FUNERAL DIRECTOR<br>Thompson Funeral Home Middletown, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br>FEB 13 1987 Julia Anderson-Randall  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |  |  |   |   |  |
|--|--|---|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOE ANDERSON COCKERELL</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 / 16 / 87</b>                   |  |  | 2b. HOUR <b>1145 PM</b>  |  |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 27, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick, MD.</b>   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Ret. Gov't Emp.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>   |  |   | 13b. COUNTY <b>Frederick</b>  |  | 13c. CITY OR TOWN <b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE <b>6434 S. Clifton Rd./21701</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Lee Roy Cockerell</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Locke Alice Yandell</b> |  |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   | 16b. SOCIAL SECURITY NO. <b>449-36-3489</b>                           |  | 17. INFORMANT ADDRESS <b>Mrs. Jacqueline D. Allen 6434 S. Clifton Rd. Frederick, Md. 21701</b> |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>  |  |   |   |  |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema</b>  |  |   |   |  |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |   |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:17 P.M. 19 87</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>115</b> <b>19 87</b> , to <b>2/16</b> <b>19 87</b> , that (I) (we) last saw the deceased alive on <b>115</b> <b>19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE <b>James A. Frizzell, M.D.</b>  |  |   | DEGREE  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED <b>2/16/87</b>                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James A. Frizzell</b>   |  |   | 22e. ADDRESS <b>300 Park Ave, Frederick, Md 21701</b>                 |  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |   | 23b. DATE <b>2-17-1987</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Washington, Md.</b>                   |   |   |  |
| 24. FUNERAL DIRECTOR <b>R.E. Dailey &amp; Son, P.A.</b>  |  |   | 1205 N. Market St. Frederick, Md. 21701                               |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 20 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Tison</b>   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this and page 4 to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |                                       |  |   |  |
|--|--|--|--|--|--|--|---------------------------------------|--|---|--|
| 1. STATE REGISTRAR   |  |  |  |  |  |  |                                       |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DONALD LEE COLLINS</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 9, 1987</b>                |  | 2b. HOUR<br><b>1130 A M</b>           |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 8 1934</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS                                      |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                  |                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>      |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lime Co.</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Frederick</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Collins</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Margaret Louise Adams</b> |  |                                       |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>220-26-0136</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Eva V. Collins, 355 West Patrick St., Frederick, Md. 21701</b>  |  |  |                                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL METASTATIC COLON CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |                                       |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |  |  |                                       |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |                                       |  |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                       |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-12</b> , 19 <b>87</b> , to <b>2-9</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2-7</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |                                       |  |   |  |
| 22b. SIGNATURE<br><b>Arthur G. Mawdsley, M.D.</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |                                       | 22c. DATE SIGNED<br><b>2/9/87</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR G. MAWDSLEY, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>11801 Fingert Rd. Monrovia, MD. 21790</b>   |  |  |                                       |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 12, 1987</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Md.</b>         |                                       |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Richard E. Smith</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1987</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                          |                                       |  |   |  |
| 24. FUNERAL HOME<br><b>Smith Keeney Basford P.A. Funeral Home</b>  |  |  |  | 25c. ADDRESS<br><b>106 E. Church St., Frederick, Md. 21701</b>   |  |  |                                       |  |   |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05005

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Guy R. CREAGER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 12, 1987</b> |   | 2b. HOUR<br><b>10:48 <sup>AM</sup></b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 24 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1214 North Market Street</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Real Estate &amp; Ins.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George W. Creager</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Keeney</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>214-10-4887</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Margaret T. Creager, 1214 N. Market St., Frederick, Md. 21701</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Colon Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 3/4 yrs</b> |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>age</b>  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>2-29-87</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-29-87</b> to <b>2-12-87</b> , that (I) (we) last saw the deceased alive on <b>12-9-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  | 22c. DATE SIGNED<br><b>2-13-87</b>   |  |
| 22b. SIGNATURE<br><b>Rex R. Martin</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Rex R. Martin</b>  |  |
| 22e. ADDRESS<br><b>220 North Market St., Frederick, Md. 21701</b>  |  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 16, 1987</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Smith, Keeney &amp; Basford Funeral Home</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1987</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Gordon</b>   |  |  |   |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other factor, event, the medical officer must be notified at once.

BP



RECEIVED

2009 OCT 11

FEB 20 2010

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05000

|  |  |   |  |  |   |   |   |  |
|--|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Barbara Julia Criss</b>   |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR <b>Feb 9 87</b> |  |   | 7b HOUR <b>6:30 P</b>   |   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>08 15 1909</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                 |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Citizens Nursing Home</b> |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b KIND OF BUSINESS OR INDUSTRY                                      |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |   |   |   |  |
| 13a STATE <b>MD</b>  |  | 13b COUNTY <b>FREDERICK</b>   |  | 13c CITY OR TOWN <b>FREDERICK</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |  |
| 13e STREET ADDRESS / ZIP CODE<br><b>6625 Willis Lane, 21701</b>  |  |   |  |  |   |   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN LILLION</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE HORVATH</b>  |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>N/A</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Pittsburgh, PA<br/>Mary Criss 112 Tenth St., Apt. 206</b>  |   |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thromboses</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Broncho-pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's Disease</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |   |  |  |   |   | APPROPRIATE INTERVAL BETWEEN LAST AND DEATH<br><b>4d</b><br><b>7d</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a  |  |   |  |  |   |   |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 21</b> , 19 <b>86</b> , to <b>Feb.</b> , 19 <b>87</b> , that (1) <del>last</del> saw the deceased alive on <b>Feb. 9</b> , 19 <b>87</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>would</del> did not view the body after death.  |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Bernard O. Thomas, Jr.</b>  |  |   |  | 22c. DATE SIGNED<br><b>Feb. 1987</b>   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard O. Thomas, Jr.</b>  |   |  |
| 22e. ADDRESS<br><b>228 N. Market St., Frederick, MD 21701</b>  |  |   |  |  |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b DATE<br><b>2/13/87</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Nicholas Cemetery</b>  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ross Township PA</b>  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>G. DOUGLAS STAUFFER 1621 Opossumtown Pike, Frederick, MD</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1987</b>  |   |   |   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |   |   |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George Franklin Crouse</b>  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 19 87</b>   |  | 2b. HOUR <b>8:21</b> <sup>A</sup>  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>07 05 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick,</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Frederick</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret./ Govt.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |
| 13a. STATE <b>Maryland</b>   |   | 13b. COUNTY <b>Frederick</b>  | 13c. CITY OR TOWN <b>Frederick</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George Edward Crouse</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Victoria Shaffer</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>Yes</b>  |   | 16b. SOCIAL SECURITY NO. <b>W.W. II 214-10-3419</b>   |  | 17. INFORMANT ADDRESS <b>Mrs. Kathleen Crouse 8010 Ridge Rd., Fred.</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Parkinson's Disease Cerebrovascular disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 86</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/15/87</b> to <b>Feb 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or was) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE <b>Casper E. Clinchy</b>  |   | DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Casper E. Clinchy</b>   |   | 22e. ADDRESS <b>804 Toll House Ave</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |   | 23b. DATE <b>2/23/87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran Cemetery</b>                             |  |
| 23d. LOCATION <b>Middletown</b>  |   | 23e. COUNTY <b>Frederick Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert E. Dailey &amp; Son F.H., PA</b>   |   | ADDRESS <b>1201 N. Market</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1987</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>James D.</b>   |   |   |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filled with the funeral director's name and address, and the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, accident, or violent event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal to another place of interment.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, in

## MEDICAL CERTIFICATION

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |  |  |   |  |   |                            |   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Della Iona DeBerry</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-14-87</b>   |  |  |  |   |  |   | 2b. HOUR<br><b>1700 M.</b> |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 3, 1907</b>   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79 YRS.</b>  |  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |                            | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>HOURS MIN.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co. MD.</b>   |  |   |  |   |                            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                |  |   |                            |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Carroll</b>   |  | 13c. CITY OR TOWN<br><b>Keymar</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE<br><b>21757</b><br><b>715 Francis Scott Key Hwy.</b> |  |   |                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Fogle</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  |  |  |   |  |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT<br><b>Anna Mae Wenschhof</b>  |  |   |  | ADDRESS<br><b>11 Blue Ridge Ave. Thurmont, MD 21788</b>  |  |   |  |   |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b><br>DUO TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUO TO, OR AS A CONSEQUENCE OF<br>(c) <b>LOW CARDIAC OUTPUT</b>  |  |   |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 d.</b><br><b>3 d.</b><br><b>3 d.</b> |                            |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:a<br><b>ANURIA (1 day) - ANGINA + year - Diabetes 6 yrs.</b>  |  |   |  |   |  |   |  |  |  |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |                            |   |  |
| 21a. ACCIDENT WAS UNDERLYNG <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |   |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |   |                            |   |  |
| 22a. I certify that (I) [this hospital] attended the deceased from <b>02-12</b> , 19 <b>87</b> , to <b>02-14</b> , 19 <b>87</b> . That (I) (we) lost<br>saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did view the body after death. |  |   |  |   |  |   |  |  |  |   |  |   |                            |   |  |
| 22b. SIGNATURE<br>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>02/16/87</b>  |  |   |  |   |                            |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIO MENONDI</b>   |  |   |  | 22e. ADDRESS<br><b># 576 TRAIL AV - / FREDERICK, MD</b>   |  |   |  |  |  |   |  |   |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/17/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rocky Hill Cem.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodsboro, Frederick, MD</b>  |  |   |  |   |                            |   |  |
| 24. FUNERAL DIRECTOR<br><b>Squires Funeral Home</b>   |  | 136 E. Baltimore St.<br><b>Taneytown, MD 21787</b>  |  |   |  | FEB 24 1987   |  | REGISTRAR'S SIGNATURE<br>  |  |   |  |   |                            |   |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |        |  |                                  |  |  |
|--|--|--|--|---|--------|--|----------------------------------|--|--|
| 1- STATE REGISTRAR   |  | DECEASED NAME (TYPE OR PRINT)  |  | FIRST   | MIDDLE | LAST   | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR A.M.                                |
|  |  | ETHEL  |  | T.  |        | Dorsey   | Feb. 4, 1987                     |  | 10:55 M.                                     |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |        | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.  |                                  | IF UNDER 1 YEAR MONTHS DAYS MIN.   |  |
| F  |  | B  |  | March 8, 1933   |        | 53   |                                  | 10 26  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                  |  |  |
| Maryland   |  | U.S.A.   |  |   |        | Frederick Co., MD.   |                                  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Frederick  |  | Frederick Memorial Hospital  |  |   |        | Housewife  |                                  |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |        |  |                                  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 13e. STREET ADDRESS / ZIP CODE   |  |
| Maryland   |  | Frederick  |  | Monrovia  |        |  |                                  | 4233 Ed Mc Clain Rd. 21770   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |        |  |                                  |  |  |
| Andrew Simms   |  |  |  | Mabel Lyles   |        |  |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |        |  |                                  |  |  |
| No   |  | 212-48-5326  |  | Carl Dorsey, Sr., Same as # 13  |        |  |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |   |        |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute cardiac arrhythmia</u>  |  |  |  |   |        |  |                                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u>   |  |  |  |   |        |  |                                  |  | 6 wks  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |   |        |  |                                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |        |  |                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus, Hypertension</u>  |  |  |  |   |        |  |                                  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |        | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |        |  |                                  |  |  |
|  |  | P.M. 19  |  |   |        |  |                                  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |        |  |                                  |  |  |
|  |  |  |  |   |        |  |                                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>78</u> to <u>2/4</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |        |  |                                  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |        |  |                                  | 22c. DATE SIGNED   |  |
| <u>Charles R. Clark MD</u>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |        |  |                                  | 2/4/87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |        |  |                                  |  |  |
| Charles R. Clark MD  |  |  |  | 4 W 7th St Frederick, Md. 21701   |        |  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |        | 23d. LOCATION CITY OR TOWN   |                                  | COUNTY STATE   |  |
| Burial   |  | 2-7-1987   |  | Fairview  |        | Carroll  |                                  | Md.  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |        | 25b. REGISTRAR'S SIGNATURE   |                                  |  |  |
| Charles W. Burrier, Jr., Sykesville, Md.   |  |  |  | FEB 09 1987   |        | Julia Davidson-Randall   |                                  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                     |  |  |  |
|---|--|---|--|---|--|---|--|---------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  | A.  |  |                     |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |  |
| Lucy  |  | L.  |  | Dotson  |  |   |  | February 25, 1987   |  | 11:25 <sub>M</sub>                           |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS                              |  |
| Female  |  | Black   |  | May 23, 1900  |  | 86  |  | MONTHS 9            |  | DAYS 2                                       |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |  |  |
| Maryland  |  | U.S.A.  |  |   |  | Frederick Co.,  |  |                     |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |  |  |
| Frederick   |  | Frederick Memorial Hospital   |  | Factory Worker  |  |   |  |                     |  |  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |                     |  |  |  |
| Maryland  |  | Frederick   |  | Mt. Airy  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13914 Prospect Rd., |  | 21771  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                     |  |  |  |
| FIRST   |  | MIDDLE  |  | LAST  |  | FIRST   |  | MIDDLE              |  | LAST   |  |
| Henry   |  | Hutchison   |  |   |  | Hanna   |  | Mae                 |  | Myers  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |  |  |
| No  |  | 219-05-2499   |  | Margaret E. Johnson, Same as # 13   |  |   |  |                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Right pneumonia and Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>gangrenous bowel s/p resection</u>  |  |   |  |   |  |   |  |                     |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |  |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                     |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY              |  | STATE  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>2-24</u> 19 <u>87</u> , to <u>2-25</u> 19 <u>87</u> , that (1) we last saw the deceased alive on <u>2-24</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) we did not view the body after death.                      |  |   |  |   |  |   |  |                     |  |  |  |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |                     |  |  |  |
| <u>[Signature]</u>  |  | MD  |  |   |  | 2-26-87   |  |                     |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                     |  |  |  |
|   |  |   |  |   |  |   |  |                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY              |  | STATE  |  |
| Burial  |  | 3-1-1987  |  | Fairview  |  |   |  | Carroll,            |  | Md.  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                     |  |  |  |
| Charles W. Burrier, Jr.,  |  | MAR 02 1987   |  | <u>[Signature]</u>  |  |   |  |                     |  |  |  |

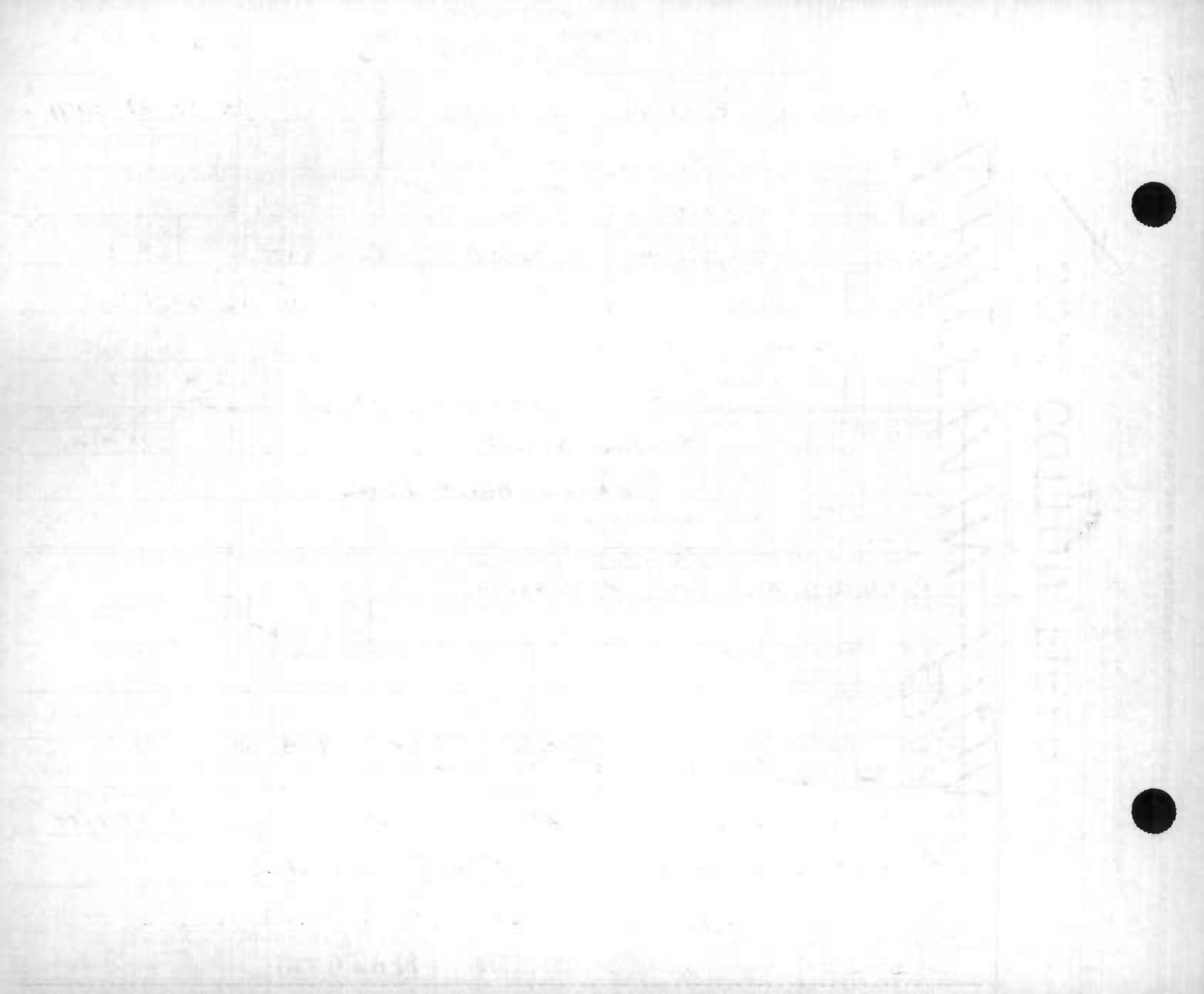


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 87 05071  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(Last, first, middle)<br>Catherine Barbara Eldridge  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 18 87  |  | 2b. HOUR<br>0741 M  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 18 1915  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Clerk                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retail   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Smithsburg   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>13201 Wolfsville Rd/21783   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul ----- Kline, Sr.  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Etta Mae Kuhn  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-26-9038   |  | 17. INFORMANT<br>ADDRESS<br>G. Sterling Eldridge 13201 Wolfsville Rd<br>Smithsburg, MD 21783  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest.</u>   |  |  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ischemic heart disease</u>  |  |  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>DIABETES MELLITUS. PNEUMONIA</u>  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 12</u> , 19 <u>87</u> , to <u>FEB 18</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>FEB 17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Michael S. Rudman</u>   |  |  |  | DEGREE<br><u>M.D.</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>2/18/87</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. CHAEL S. RUDMAN</u>   |  |  |  | 22e. ADDRESS<br><u>Middletown, MD</u>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Feb. 21, 1987   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion U. Methodist   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Myersville Frederick Maryland                     |  |   |  |
| 24. FUNERAL HOME<br><u>Ricketts Funeral Home</u>   |  |  |  | ADDRESS<br><u>Myersville, MD 21773</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 24 1987</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John B. ...</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

Virginia Thelma Everhart

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 05072  
REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Virginia Thelma EVERHART  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 18, 1987                  |  | 2b. HOUR P.<br>3:40 M   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 4, 1907   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br>Frederick   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retail  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |   | 13b. COUNTY<br>Frederick  | 13c. CITY OR TOWN<br>Frederick   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul Eugene Werking  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertie V. Strothers      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>573-12-3193   |   | 17. INFORMANT<br>ADDRESS<br>Kenneth P. Taylor, 6193 Viewside Drive<br>Frederick, Md. 21701 |   |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Rt. thoracotomy, lobectomy for cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>emphysema - on respirator post-operative.</u>                                     |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Colonary disease</u>  |  |  |   |   |  |
| 19a. DATE OF OPERATION<br>2-12-87   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CANCER - Rt. thoracotomy<br>B.L. lobectomy | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/87</u> 19 <u>87</u> to <u>2/18/87</u> 19 <u>87</u> , that (I) (we) lost<br>saw the deceased alive on <u>2/18/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Nicholas P. Foris</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>2/18/87</u>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NICHOLAS P. FORIS  |  | 22e. ADDRESS<br>27 W. 7 St. Frederick, Md. 21701   |   |   |  |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial               | 23b. DATE<br>Feb. 20, 1987 | 23c. NAME OF CEMETERY OR CREMATORY<br>Park Heights Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brunswick, Frederick, Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Smith, Keeney & Basford Funeral Home |                            | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1987                | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Denison-Rodgers</u>              |
| 106 East Church Street, Frederick, Md. 21701                         |                            |   |   |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following tags 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary Evelyn Fout</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-7-87</b>                   |   |  | 2b. HOUR<br><b>0420 AM</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/30/103</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0420 AM</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Lee Smith</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lena Horman</b>    |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>519 Magnolia Ave., 21701</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-74-5797</b>                         |   | 17. INFORMANT <b>Mrs. Phyllis F. Sink</b><br><b>3166 Flamingo Dr., Decatur, Ga., 30033</b>                   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                               |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/5/87</b> , 19____, to <b>2/7/87</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>2/6/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.                 |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Austin Pearre, Jr.</b>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/7/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. A. Austin Pearre, Jr.</b>   |  |   | 22e. ADDRESS<br><b>804 Toll House Ave., Frederick, Md. 21701</b>       |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Feb. 11, 1987</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>                  |  |  |
| 24. FUNERAL DIRECTOR <b>Smith, Keeney &amp; Basford Funeral Home</b><br>106 East Church St., Frederick, Md. 21701   |  |   |  |   | 25a. DATE RECD. BY REGISTRAR <b>FEB 18 1987</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Julia Denson-Randall</b> |  |   |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 05074  
REG. NO.FOR  
1 - STATE  
REGISTRAR

|   |  |   |   |  |   |  |
|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(1st, middle, last)<br>Essie Mary Frye  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02/17/87                                       |  | 2b. HOUR<br>6 <sup>30</sup> M   |  |
| 3. SEX<br>F.  | 4. RACE<br>C.  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/31/01   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 yrs YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cafeteria Manager |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Public School  |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Frederick  | 13c. CITY OR TOWN<br>Brunswick   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Hawes  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mollie Baker                         |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br>Unknown   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-01-4446  |   | 17. INFORMANT<br>ADDRESS<br>Elizabeth Myers 116 Central Ave., Md. 21716 Brunswick  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cerebrovascular accident<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 hrs |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2/9 75 2/17 87 0  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17 87, to 2/17 87, that (I) (we) last saw the deceased alive on 2/17 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>W. A. Augmer  |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/18/87  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. A. Augmer   |  | 22e. ADDRESS<br>Brunswick, Md. 21716  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Feb. 20, 1987  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Union Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lovettsville (Loudoun) Virginia  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown Funeral Home P.O. Box 320   |  | ADDRESS<br>Virginia 22080   |   | 25a. DATE REC'D BY REGISTRAR<br>FEB 24 1987  |   | 25b. REGISTRAR'S SIGNATURE   |

MEDICAL CERTIFICATION

CONCILIATION FIBER

WHITE/BLACK



045365 FEB 28 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05075

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Russell Clayton Goodman  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 20 87 |   |  | 2b. HOUR<br>0355 M   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 04 1934  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>FREDERICK MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>FREDERICK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FREDERICK MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONSTRUCTION.  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME   |  |  |  |   |  |  |  |
| 13a. STATE<br>MD  |  |  |  | 13b. COUNTY<br>FREDERICK  |  | 13c. CITY OR TOWN<br>FREDERICK   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>E. RUSSEL GOODMAN   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET DeFrehn   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Korean Conf.   |  | 17. INFORMANT<br>ADDRESS<br>Frederick, MD<br>Sara Goodman 10621 Lenhart Rd.,   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Guadraplegia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>chronic urinary tract infection - surgical abscess</u>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. Nov 12 1985  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>fell from ladder - skull fracture   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Residence (working)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glenary Mont. Md  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from Feb 12, 1987, to Feb 19, 1987, that (I) (we) last saw the deceased alive on Feb 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Lloyd H. Halvorsen  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>2/20/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lloyd H. Halvorsen   |  |  |  | 22e. ADDRESS<br>1475 Tany Ave Frederick Md  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/23/87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Utica Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Utica Frederick MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. DOUGLAS STAUFFER   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1987  |  | 25b. REGISTRAR'S SIGNATURE<br>John E. Fisher   |  |
| 1621 Opossumtown Pike, Frederick, MD 21701  |  |  |  |   |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the body is released for burial or cremation.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |                                      |   |   |  |  |
|--|--|---|--|--|--------------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marvis Lorena Grimes</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 19, 1987</b>              |  |                                      | 2b. HOUR<br><b>1:55</b> P.<br>M.  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 25, 1915</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>71 11 24</b>                      |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co., MD.</b>                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Airy</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5556 Buffalo Road</b> |  |  |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Restaurant Owner</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Mt. Airy</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ferdinand Wise</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Mae Tucker</b> |  |                                      |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, FATHER UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-14-6861</b>   |  | 17. INFORMANT ADDRESS<br><b>James L. Grimes, Sr., Same as # 13</b>   |                                      |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u><b>Emphysema</b></u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |  |                                      |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u><b>Coronary Heart Failure</b></u>   |  |   |  |  |                                      |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                      |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u><b>1-20</b></u> 19 <u><b>87</b></u> , to <u><b>2-19</b></u> 19 <u><b>87</b></u> , that (I) (we) lost<br>saw the deceased alive on <u><b>2-11</b></u> 19 <u><b>87</b></u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (and) (not) view the body after death. |  |   |  |  |                                      |   |   |  |  |
| 22b. SIGNATURE<br><u><b>[Signature]</b></u>  |  |   |  | DEGREE <u><b>MO</b></u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      |   |   | 22c. DATE SIGNED<br><b>2-24-87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |                                      |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-23-1987</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Locust Grove</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Md.</b>                         |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Charles W. Burrier, Jr.,</b> ADDRESS <b>Sykesville, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1987</b>  |                                      | 25b. REGISTRAR'S SIGNATURE<br><u><b>[Signature]</b></u>                                     |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove certificates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic events, the medical examiner must be notified at once.

BP







RECEIVED  
FEB 24 1987

BOX 1011M LIPK

FEB 24 1987  
FBI - NEW YORK

044451 FEB 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the Division of Vital Records. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 48 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |  |  | REG. NO. |
|--|--|--|---|---|--|--|---|--|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RALPH EUGENE GUM, Sr.  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/5/87                                  |  |   | 2b. HOUR<br>2:02A M  |  |          |
| 3. SEX<br>Male   |  | 4. RACE<br>CAUC.   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2/5/19  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.  |   |  |  |          |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Brakeman Railroad  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Frederick   |   | 13c. CITY OR TOWN<br>Brunswick  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>715 East Potomac St. / 21716   |  |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Wade Gum   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Frances Skidmore   |  |  |   |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>236-03-0184  |  | 17. INFORMANT<br>ADDRESS<br>Marie E. Gum - Brunswick, Md. 715 E. Potomac St. 21716   |   |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>which degenerated into ASYSTOLE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>coronary artery disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. |  |  |   |   |  |  |   |  |  |          |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I did) (did not) view the body after death.  |  |  |   |   |  |  |   |  |  |          |
| 22b. SIGNATURE<br>John Vitarello MD  |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/7/87   |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John A. Vitarello MD  |  |  |   |   |  | 22e. ADDRESS<br>335 Park Avenue, Frederick, Md.  |   |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2/7/87   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Park Heights Cem.                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brunswick, Frederick, Md. |  |  |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>John T. Williams Funeral Home Brunswick, Md.   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1987   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Gordon-Randall   |  |          |

BP

1954-1955

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

1954 JUN 10 10:00 AM

FEB 12 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Thereafter, the funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal of the body from the jurisdiction. (See instructions on reverse.)

IMPORTANT: If item 21 is marked as item 18 shows any conditions, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 87 05077   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>CARROLL ETZLER HARRP</b>   |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>FEBRUARY 02/27/87</b>   |  |  |  | 2b HOUR<br><b>3:30 AM</b>   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>08/08/06</b>   |  | 6 AGE<br>(IN YEARS LAST BIRTHDAY) <b>80</b>                              |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK</b>                  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>FREDERICK</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(TYPE OR PRINT) <b>MERIDIAN NURSING HOME</b> |  |   |  | 12a USUAL OCCUPATION<br>(TYPE OR PRINT) <b>SALESMAN</b>                  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>LIME CO.</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD</b>   |  |  |  | 13b CITY OR TOWN <b>FREDERICK</b>   |  | 13c STREET ADDRESS, ZIP CODE<br><b>10908 GREEN VALLEY RD. 21791</b>      |  | 13d TYPE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14 FATHER'S NAME<br><b>ROY B. HARP</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME<br><b>ALICE M. ETZLER</b>   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>NO</b>  |  | 16b SOCIAL SECURITY NO.<br><b>213-01-6030</b>  |  | 17 INFORMANT ADDRESS<br><b>GURNON F. WORKING F. &amp; M. NATIONAL BANK</b>  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>HEART FAILURE (CHRONIC)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MITRAL / TRICUSPID INSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                       |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)                                       |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a I certify that (I) (the hospital) attended the deceased from <b>NOVEMBER 19 73</b> to <b>FEBRUARY 19 87</b> that (I) (we) last saw the deceased alive on <b>26 February 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b SIGNATURE<br><b>George I. Smith Jr.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  |  |  | 22c DATE SIGNED<br><b>2-27-87</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE I. SMITH, JR.</b>  |  |  |  | 22e ADDRESS<br><b>904 TOLLHOUSE AVE. FREDERICK, MD</b>  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b DATE<br><b>03/02/87</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>CHAPEL CEMETERY</b>   |  | 23d LOCATION<br>CITY OR TOWN STATE<br><b>NR. LIBERTYTOWN FRED. MD</b>    |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>D. D. HARTZLER</b>   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 02 1987</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Randall</b>               |  |   |  |

100

20% COLIC 1188

CHILD WALK

(11/11/11)

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45454 FEB 27 1987

#18a., 22a., G-625, by STATE OF MARYLAND  
FOR Med. Ex., / 3/26/87 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
REGISTRAR Gbj. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05080

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. KEEP WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST. BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Carl Lee Heffner

2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR  
2 12 1987

2b. HOUR  
11:50 a.m.

3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR  
Oct. 17, 1946 6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.

7c. DATE PRONOUNCED DEAD MONTH DAY YEAR  
2 12 1987

7d. HOUR  
11:50 a.m.

7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. 7f. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD

10. CITY OR TOWN OF DEATH Frederick 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer 12b. KIND OF BUSINESS OR INDUSTRY Concrete

13a. STATE Maryland 13b. CITY OR TOWN Frederick 13c. CITY OR TOWN Brunswick 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 219 East Potomac St. / 21716

14. FATHER'S NAME FIRST MIDDLE LAST Edward Lee Heffner 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Elaine Sigler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) Vietnam War 16b. SOCIAL SECURITY NO. 219-46-3270 17. INFORMANT ADDRESS 4304 Catholic Rd. Edward L. Heffner - Knows Like, Md. 21758

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) - Subdural hematoma with seizure  
DUE TO, OR AS A CONSEQUENCE OF  
(b) disorder with complications  
DUE TO, OR AS A CONSEQUENCE OF  
(c) 888

19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10.

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
7+ P.M. 2 11 1987 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject fell

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
219 E. Potomac St. Brunswick, Frederick Co. Md.

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE William M. Zane TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 2/13/87

EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. ADDRESS 111 Penn St. Balto. MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 2/16/87 23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gar. 23d. LOCATION CITY OR TOWN COUNTY STATE  
Frederick, Frederick, Md.

24. FUNERAL DIRECTOR NAME ADDRESS John T. Williams Funeral Home Brunswick, Md. 25a. DATE REC'D. BY REGISTRAR FEB 24 1987 25b. REGISTRAR'S SIGNATURE Wanda Davidson-Randall

07/84 35M BR 507 DHMH - 17 (VR A15 ME (5))

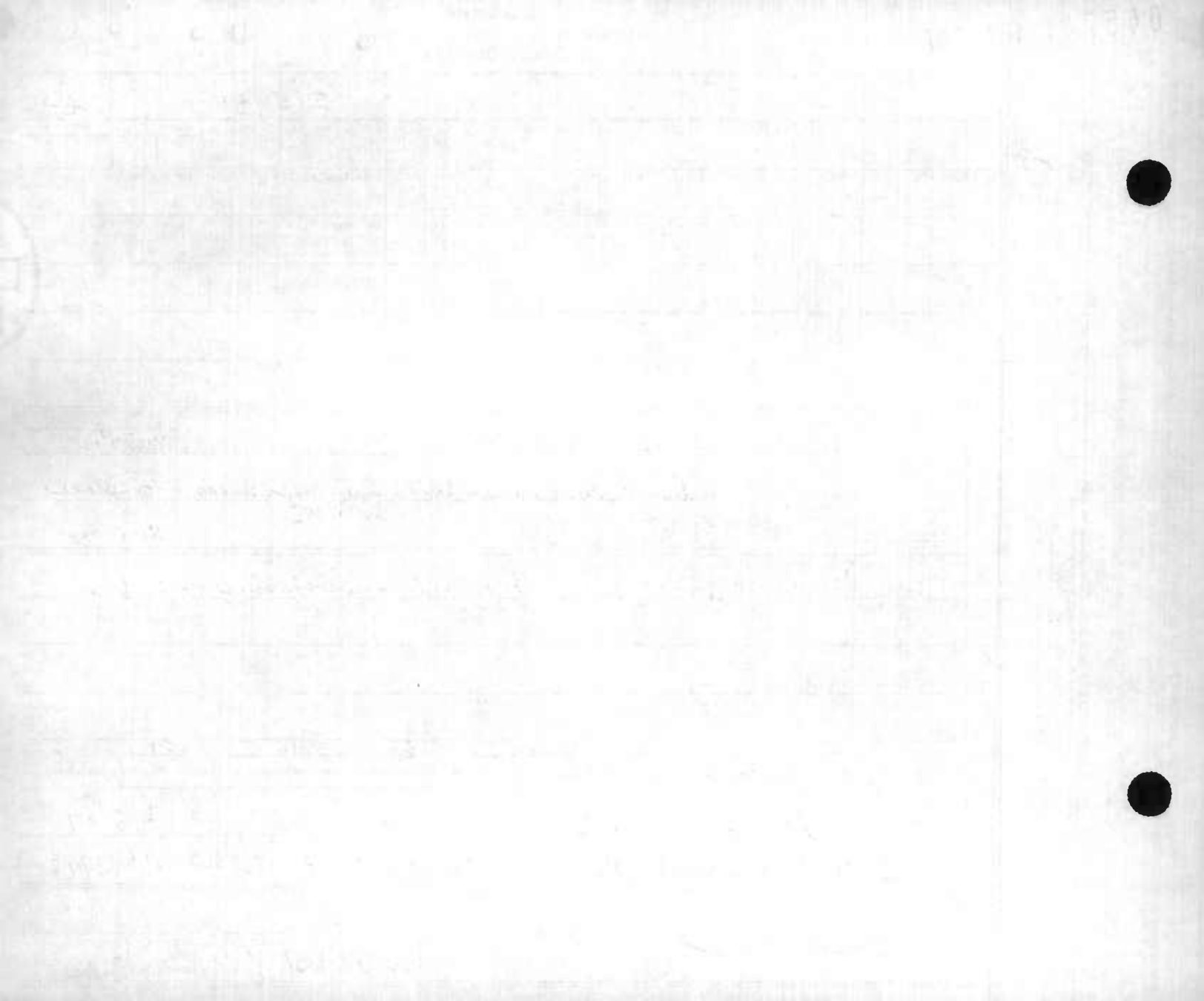


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. You may also retain a copy of this certificate for your records. You should retain a copy of this certificate with the State Dept. of Health and Mental Hygiene for filing. (IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be called to examine the body.)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  | REG. NO.<br>05081  |  |
|---|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES CLIFFORD HEWITT</b>  |  |   |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/5/87</b>  |  | 2b. HOUR<br><b>245 P.M.</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 27, 1926</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK, COUNTY MD.</b>                        |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FREDERICK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FREDERICK MEMORIAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ANIMAL CARETAKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LAB</b>  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |  |   |   | 13b. COUNTY<br><b>FREDERICK</b>   |  | 13c. CITY OR TOWN<br><b>THURMONT</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANKLIN W. HEWITT</b>   |  |   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NANNIE B. RICE</b>                      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>KOREAN</b>  |  | 17. INFORMANT<br><b>KATHY HEWITT</b>  |   | ADDRESS<br><b>6508 F. MOUNTAINDALE RD. THURMONT, MARYLAND 21788</b>                         |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>  |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Intercoronary artery disease - angina pectoris</b>   |  |   |  |   |   |   |  |  | <b>15 years</b>  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus</b>  |  |   |  |   |   |   |  |  | <b>10 years</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Hypertension 16 years. Severe atherosclerotic &amp; chronic disease of aorta &amp; arteries.</b>   |  |   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>63</b> , to <b>July 5</b> , 19 <b>87</b> that (I) (we) last saw the deceased alive on <b>2/2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. |  |   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James E Stoner, Jr</b>   |  |   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/5/87</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES E STONER, JR</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>19 FREDERICK ST. WALKERSVILLE, MD. 21793</b>                             |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>2/9/87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RESTHAVEN MEM. GARDENS</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FREDERICK Maryland</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT E. DAILEY &amp; SON, P.A.</b>   |  |   |  |   |   | ADDRESS<br><b>615 E. MAIN ST.</b>   |  | 25a. DATE RECD. BY REGISTRAR<br><b>MAR 02 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |



045325 FEB 23 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| DECEASED NAME<br>(TYPE OR PRINT) <b>GuaniTa Virginia Himes</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/14/87</b>   |  | 2b. HOUR<br><b>0042m</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 25, 1931</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Technician</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance Co.</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  | 13b. CITY OR TOWN<br><b>Frederick</b>   | 13c. CITY OR TOWN<br><b>Mt. Airy</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George E. Smith</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Henrietta E. Dinterman</b>  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>No</b>   | 17. INFORMANT ADDRESS<br><b>10602 Old National Pike</b><br><b>Richard M. Himes, Sr., Mt. Airy, Md. 21771</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 8, 1987</b> to <b>Feb 8, 1987</b> , that (I) (we) last saw the deceased alive on <b>Feb 26, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Barakat</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kusay BARAKAT</b>  |   | 22e. ADDRESS<br><b>335 Park Avenue Frederick MD 21701</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Feb. 17, 1987</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Hill Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Monrovia, Frederick, Md.</b>        |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Smith, Keeney &amp; Basford Funeral Home</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1987</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Dinterman</b>                                  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |  |  |  |  |   |   |  |
|---|--|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM ROYSTELL HOOPER</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 23, 1987</b>   |  | 2b HOUR<br>a m<br><b>9</b>   |  |   |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Caucasian</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 2, 1923</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b><br>YRS MONTHS DAYS HOURS MIN.  |   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick, MD</b>  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3 North Court Street</b> |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>                           |   |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Frederick</b>  |  | 13c CITY OR TOWN<br><b>Frederick</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e STREET ADDRESS / ZIP CODE<br><b>3 N. Court Street/21701</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George William Hooper</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Mary Simmons</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |   | 16b SOCIAL SECURITY NO<br><b>215-14-1509</b>  |  |
| 17 INFORMANT<br><b>Mr. Joseph O. Hooper</b>   |  |   |  | ADDRESS<br><b>411 Fairview Avenue Frederick, Md. 21701</b>   |  |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic Heart Dis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |  |   |   |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Sept 17</b> 19 <b>71</b> to <b>Feb 23</b> 19 <b>87</b> that (I) (we) lost saw the deceased alive on <b>Feb 24</b> 19 <b>87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |   |  |  |  |  |   |   |  |
| 22b SIGNATURE<br><b>Thomas E. Stone</b>   |  |   | DEGREE<br><b>M.D.</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br><b>2-24-1987</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas E. Stone, M.D.</b>  |  |   | 22e ADDRESS<br><b>4 West Third Street Frederick, Md. 21701</b>   |  |  |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b DATE<br><b>2-26-1987</b>                                     |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>                    |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b> |   |  |
| 24 FUNERAL DIRECTOR<br><b>R. E. DALLEY &amp; SON, P.A.</b>  |  |   | 1201 N. Market St.<br><b>Frederick, Md. 21701</b>                |  |  | 25 DATE REC'D. BY REGISTRAR<br><b>MAR 02 1987</b>  |   | REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then detach page 4 and return it to the funeral director. Page 4 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 about any injury, or any significant event, the medical examiner should be notified.

20% GILSON FIBER

W. Frank J. J. J. J. J.

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MAR 10

Horning, Gerald Lindberg

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

05084

REG. NO.

|  |  |  |   |   |                     |   |  |  |  |  |  |
|--|--|--|---|---|---------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GERALD LINDBERG HORNING  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/25/87                      |   | 2b. HOUR<br>1540 AM |   |  |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 12 1927  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MINS.   |  | 8. UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   |   |                     | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Truck Driver                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Stone Quarry  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Carroll Keymar  |  |  |   |   |                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>804 Francis Scott Key Hwy. 21757   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Horning  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maraude Greenholtz |   |                     |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II  |  | 16b. SOCIAL SECURITY NO.<br>219-20-3789  |   | 17. INFORMANT<br>Esther Horning   |                     | ADDRESS<br>804 F.S. Key Hwy.<br>Keymar, MD 21757  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Tobacco Inhalation</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |  |   |   |                     |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years<br>yrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |   |                     |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                     |   |  |  |  |  |  |
| 22a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 22c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |   |  |  |  |  |  |
| 23. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) see the body after death.                                       |  |  |   |   |                     |   |  |  |  |  |  |
| 24. SIGNATURE<br>Allen J. Olson  |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                     | 25. DATE SIGNED<br>2/25   |  |  |  |  |  |
| 26. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allen J. Olson   |  | 27. ADDRESS<br>1475 TANEY AVE Frederick  |   |   |                     |   |  |  |  |  |  |
| 28a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 28b. DATE<br>2/28/87   |   | 28c. NAME OF CEMETERY OR CREMATORY<br>Church of God   |                     | 28d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Uniontown, Carroll, Maryland                      |  |  |  |  |  |
| 29. FUNERAL DIRECTOR<br>NAME<br>Skiles Funeral Homes   |  | 136 E. Baltimore St.<br>ADDRESS<br>Taneytown, Md. 21787  |   | 75a. DATE REC'D. BY REGISTRAR<br>MAR 03 1987  |                     | 75b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05085

|   |  |  |   |  |  |   |  |  |  |
|---|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth HOUGH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 1, 1987</b>          |  | 2b. HOUR<br><b>4:50 AM</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 17, 1921</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>65</b><br>YRS. MONTHS DAYS HOURS MIN.                   |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Northampton Manor Nursing Home</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembly</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electronic Corp.</b><br><b>21701</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>111 East Patrick Street</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur E. Fauble</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elva Mae Danner</b> |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 17. INFORMANT ADDRESS<br><b>Waverley Drive, Apt. F-101</b><br><b>Charles F. Hough, Sr., Frederick, Md. 21701</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASHD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years +</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Diabetes Mellitus</b>  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>82</b> , to <b>Feb. 1</b> , 19 <b>87</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 30</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.               |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W. J. Riddick</b>  |  |  |   | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>2/3/87</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Willis J. Riddick MD</b>  |  |  |   | 22e. ADDRESS<br><b>21701 Parkview Medical Center, Frederick, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 4, 1987</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brunswick, Frederick, Md.</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John T. Williams Funeral Home</b><br><b>Brunswick, Md. 21716</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR'S REGISTRATION SIGNATURE<br><b>FEB 10 1987</b>   |  |   |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

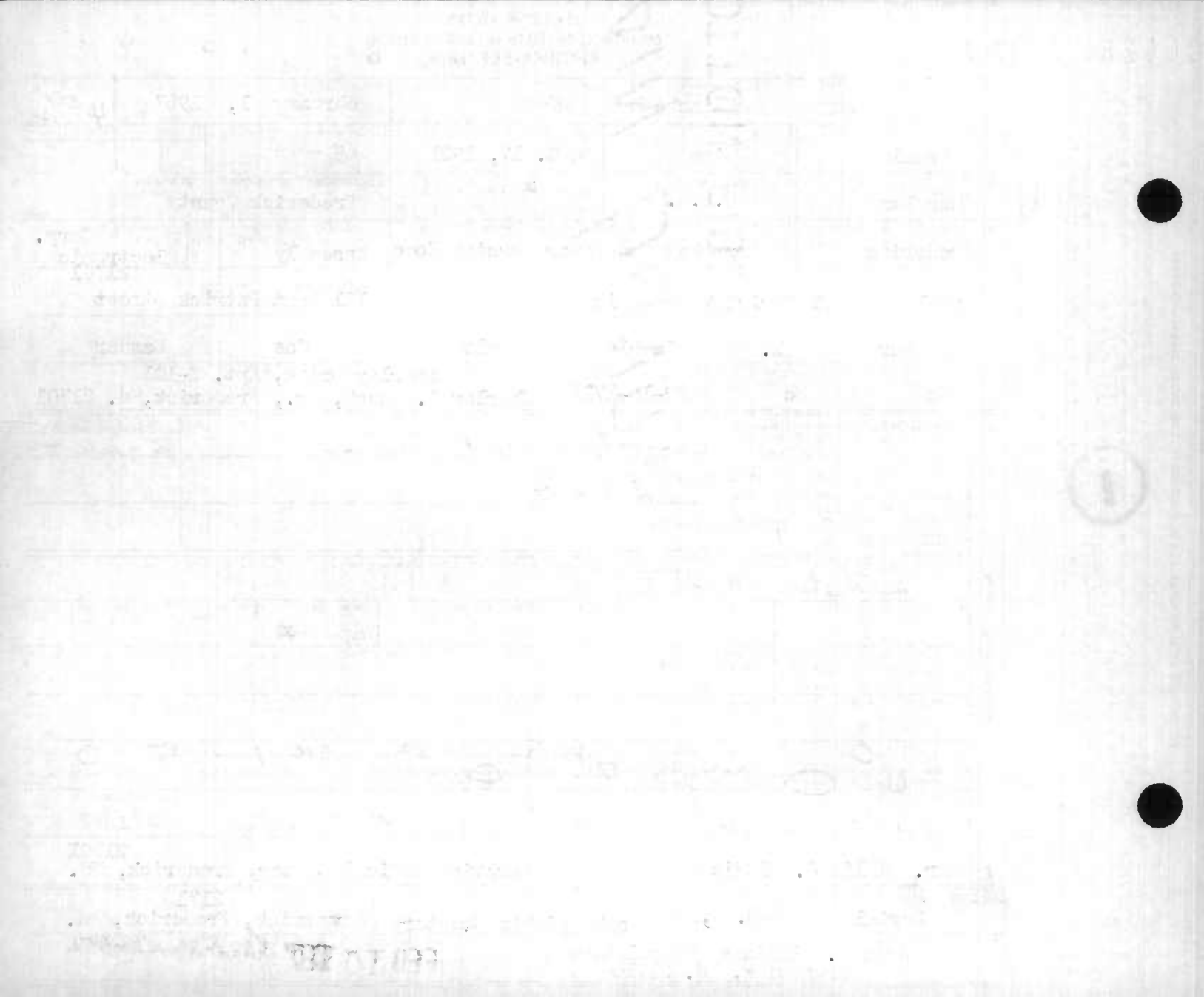
BP. \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please retain the certificate papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

(IMPORTANT: If item 21 is marked as, there showing any injury, or other traumatic event, the medical examiner must be notified at once.)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 states any injury, or other traumatic event, or medical examination that the medical examiner

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(1) PRINTED<br>Edgar William Hyde   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 3 1987   |   |  | 2b. HOUR<br>2120 <sup>P</sup>  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11/7/15   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.                                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dispatcher.      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Quarry  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>212 John Hyde Rd 21157                       |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John S Hyde   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Lippy   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES WWII        |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>216-03-6904   |  |  | 17. INFORMANT<br>Margaret Hyde   |   |  | ADDRESS<br>Westminster, Md<br>212 John Hyde Rd                                       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                       |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><u>Pulmonary Emboli</u>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>1/14/87   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Pulmonary Emboli   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> , 19 <u>87</u> , to <u>2/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Max Wingard MD  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>2/3/87   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Max Wingard  |  |  | 22e. ADDRESS<br>27 W. 7th St, Frederick, MD 21701  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2/6/87  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LEISTER'S CEMETERY                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westminster Carroll MD |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>D. D. S. S. S.  |  |  | ADDRESS<br>New Windsor   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 09 1987                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                 |  |  |

BP

0471

100% COTTON GIBBS

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Davis JOHNSTON</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 21, 1987</b>  |  | 2b. HOUR<br><b>3:00P<sub>M</sub></b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 15, 1902</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD.                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Brunswick</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>812 Fourth Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Conductor</b>                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O Railroad</b>                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Frederick</b> 13c. CITY OR TOWN <b>Brunswick</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br><b>812 Fourth Ave., 21716</b>                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jefferson Davis Johnston</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Copenhagen</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>705-09-9293</b>  | 17. INFORMANT <b>Mrs. Hazel P. Johnston</b> ADDRESS<br><b>812 Fourth Ave., Brunswick, Md. 21716</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma of the colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> to <b>2/21</b> 19 <b>87</b> , that (I) (we) lost <b>2/20</b> <b>19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Kathleen W Stern MD</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>2/22/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Kathleen Stern</b>  |   | 22e. ADDRESS<br><b>610 9th Avenue Brunswick, Md. 21716</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Feb. 24, 1987</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brunswick, Frederick, Md.</b>                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Smith, Keeney &amp; Basford</b> ADDRESS <b>106 East Church St., Frederick, Md. 21701</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1987</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swinson-Randall</b>  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other illness, the medical examiner must be notified at once.

044027 FEB 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |   |   |  |  |
|--|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LILLIAN BARBARA JONES               |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 2, 1987                   |   |   | 2b. HOUR<br>9:03 P.M.   |   |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 20 1897   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Frederick   |   | 13c. CITY OR TOWN<br>Frederick  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ernst H. Behncke                    |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna Joachim             |   |   | 13e. STREET ADDRESS / ZIP CODE<br>57 W. Patrick Street 21701                  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-84-4274 |   | 17. INFORMANT niece<br>5006 Chorley Woods Way<br>Margaret Chirieleison Silver Spring, Md. 20906 |   |   |  |  |

## MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) POST - OP<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Renal Failure; Hepatic Failure  |  |  |  |
| 19a. DATE OF OPERATION<br>1/27/87  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PERFORATED GASTRIC ULCER   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from MAY 28, 1952, to FEBRUARY 2, 1987, that (I) (we) last saw the deceased alive on FEBRUARY 2, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>George I. Smith, Jr. M.D.  |  | 22c. DATE SIGNED<br>Feb. 3, 1987   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George I. Smith, Jr., M.D.  |  | 22e. ADDRESS<br>804 Toll House Ave., Frederick 21701   |  |

|  |  |                           |  |  |  |  |  |
|--|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb. 6, 1987 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Prince Georges Md. |  |
| 24. FUNERAL DIRECTOR NAME<br>Francis J. Collins, Jr. |  |                           |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 13 1987               |  | 25b. REGISTRAR'S SIGNATURE<br>John Frederick Pender                        |  |
| 500 University Blvd. W., Silver Spring, Md. 20906    |  |                           |  |  |  |  |  |

120% COOL PIPE



144085 FEB 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |   |  |  | REG. NO. 05087 |  |
|---|--|--|--|--|---|--|---|--|--|----------------|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |   |  |   |  |  |                |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Virginia Mary Keesecker  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>February 2, 1987                                     |  |   | 2b HOUR<br>1040 A  |  |                |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>May 7, 1906  |   | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br>80 YRS   |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS   |  |                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County MD.  |   |  |  |                |  |
| 10 CITY OR TOWN OF DEATH<br>Frederick   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owned & Operated   |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Restaurant   |  |                |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>Frederick  |  | 13c CITY OR TOWN<br>Frederick  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e STREET ADDRESS / ZIP CODE<br>5736 Butterfly Lane 21701   |  |                |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Charles William Suter   |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bertha E. Bowers                           |  |   |  |  |                |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None     |  | 17 INFORMATION ADDRESS<br>Miss Anna Ray Suter<br>1810 Swansea Rd., Baltimore, Md. 21239 |  |   |  |  |                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT ? EMBOLIC<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF ATRIAL FIBRILLATION<br>(c) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIO-VASC. DISEASE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |   |  |   |  |  |                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE; DIABETES MELLITUS   |  |  |  |  |   |  |   |  |  |                |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |  |   |  |  |                |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                |  |
| 22a I certify that (I) (this hospital) attended the deceased from JANUARY 31, 1987 to FEBRUARY 2, 1987, that (I) (we) last saw the deceased alive on FEBRUARY 2, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |   |  |  |                |  |
| 22b SIGNATURE<br>George I. Smith, Jr. M.D.  |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br>February 2, 1987  |  |                |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>George I. Smith, Jr. MD   |  |  |  |  | 22e ADDRESS<br>804 Toll House Ave., Frederick, Md. 21701                                |  |   |  |  |                |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b DATE<br>Feb. 5, 1987   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Linden Hills Cemetery                              |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md. |  |  |                |  |
| 24 FUNERAL DIRECTOR<br>Smith, Keeney & Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701  |  |  |  |  | 25a DATE REC'D. BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE   |  |  |                |  |



1940  
JAN 1, 1940  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

[Large block of illegible text, likely a memorandum or report body.]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Grace G. KING  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 23, 1987 |   |  | 2b. HOUR P.M.<br>8:25 P.M.  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 5, 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Frederick   |   | 13c. CITY OR TOWN<br>Middletown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3096 Lockwood Drive, 21769   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Swope  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Florence Poole  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None  |   | 17. INFORMANT ADDRESS<br>Mrs. Ruth Zembower, 3096 Lockwood Drive, Middletown, Md. 21769   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastric Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mitral Regurgitation</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Sherman Kahan</i>  |  |  |   | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>2/25/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Sherman Kahan, M.D.  |  |  |   | 22e. ADDRESS<br>4 West Seventh Street, Frederick, Md. 21701   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Feb. 26, 1987   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>Smith, Keeney and Basford Funeral Home<br>106 East Church Street, Frederick, Md. 21701  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1987   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Seaton-Randall</i>                                       |  |  |  |

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045374 FEB 27 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05091

FOR  
1. STATE  
REGISTRAR

|  |  |  |   |   |                                |  |   |  |  |
|--|--|--|---|---|--------------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna Kate Koogle  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 17, 1987    |   |                                | 2b. HOUR<br>3:30 P. M.   |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 1, 1891  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>31 S. Jefferson St. |   |   |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>seamstress |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>self-employed   |  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Fred.                                    |   | 13c. CITY OR TOWN<br>Frederick |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John William Dorsey Koogle   |  |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE<br>Emma Poffenberger |   |                                |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-30-9283   |   | 17. INFORMANT ADDRESS<br>Charlotte Kessinger Frederick, md.   |                                |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiomyopathy of Hypertensive Origin</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>50 years |  |  |   |   |                                |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |   |   |                                |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/20/86</u> 19 <u>86</u> , to <u>2/17/87</u> 19 <u>87</u> . That (I) (we) last saw the deceased alive on <u>11/20/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (If not, I did not view the body after death).                                   |  |  |   |   |                                |  |   |  |  |
| 22b. SIGNATURE<br><u>R. L. Kaufman</u>   |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                |  |   | 22c. DATE SIGNED<br>2/19/87  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT L. KAUFMAN   |  | 22e. ADDRESS<br>FREDERICK, MD. 21701   |   |   |                                |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>Feb. 18, 1987   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Smithsburg Crematory  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Smithsburg Wash. Md.             |   |  |  |
| 24. FUNERAL DIRECTOR<br>Thompson Funeral Home Middletown, Md.<br>21769   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1987  |                                | 25b. REGISTRAR'S SIGNATURE<br>Julia Benson                                     |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

BP

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs.]

043611 FEB 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 05092

FOR  
STATE  
REGISTRAR

|  |  |   |   |  |                                     |   |  |   |  |
|--|--|---|---|--|-------------------------------------|---|--|---|--|
| 1- DECEASED NAME<br>(TYPE OR PRINT)<br><b>BELVA FRANCES LENHART</b>              |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>02 03 87</b>                   |  |                                     | 2b HOUR<br><b>8:48 P.M.</b>   |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 24 1896</b>   |                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b> |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick, Md.</b>                        |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Thurmont</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11223 Old Frederick Rd.</b> |   |  |                                     | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>None</b>             |  |
| 13a STATE<br><b>Maryland</b>   |  |   | 13b COUNTY<br><b>Frederick</b>  |  | 13c CITY OR TOWN<br><b>Thurmont</b> |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lycurgus Flanigan</b>                |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Powell</b> |  |                                     | 13e STREET ADDRESS / ZIP CODE<br><b>11223 Old Frederick Rd. / 21788</b>             |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-36-6725</b>  |   | 17 INFORMANT<br><b>Miss Evalene Lenhart</b>  |                                     |   | ADDRESS<br><b>Thurmont, Md. 21788</b>  |   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Extension of Cerebral vascular disease</b>  |  |   |  | <b>2 years</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Arteriosclerotic vascular disease</b>   |  |   |  | <b>10 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><b>None</b>   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/7</b> , 19 <b>85</b> , to <b>Present</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>1/30</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b SIGNATURE<br><b>LeRoy T. Davis</b>  |  |   |  | DEGREE<br><b>M.D.</b>  |  |
| 22c DATE SIGNED<br><b>2-5-87</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LeRoy T. Davis, M.D.</b>   |  |   |  | 22e ADDRESS<br><b>801 Toll House Ave. Frederick, Md. 21701</b>   |  |

|   |  |                           |  |  |  |   |  |
|---|--|---------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                             |  | 23b DATE<br><b>2-6-87</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Utica Cemetery</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Utica Frederick Md.</b> |  |
| 24 FUNERAL DIRECTOR'S NAME (TYPE OR PRINT)<br><b>Robert E. Dailey &amp; Son, P.A.</b> |  |                           |  | ADDRESS<br><b>1201 N. Market Frederick, MD.</b>            |  | 25a DATE REC'D. BY REGISTRAR<br><b>FEB 09 1987</b>                      |  |
|   |  |                           |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 21a, show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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100% COTTON

100% COTTON

100% COTTON



100% COTTON

045571 FEB 21

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093  
REG. NO.

|   |         |  |  |   |                               |   |   |                                      |                                |   |
|---|---------|--|--|---|-------------------------------|---|---|--------------------------------------|--------------------------------|---|
| 1- FOR<br>STATE<br>REGISTRAR  |         | DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE                        | LAST  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |                                      | XX MONTH DAY YEAR              | 2b. HOUR  |
|   |         | MICHAEL  |  |   |                               | JEAN  | LEWIS                                     |                                      | 2-19-87 19                     | M   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | IF UNDER 1 YR.<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN.            |                                      | 2c. DATE<br>PRONOUNCED<br>DEAD | 2d. HOUR  |
| MALE  | WHITE   | June 16, 1948  |  | 38 YRS.   |                               |   |   |                                      | 2-19-87 19                     | 11:15A  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                    |   |                                      |                                |   |
| Washington, D.C.  |         | U.S.A.   |  |   |                               | Frederick County MD.  |   |                                      |                                |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)        |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                                |   |
| Frederick   |         | #3 Commerce Bldg.  |  |   |                               | Property Manager  |   | Comm. Build.                         |                                |   |
| 13a. STATE  |         |  |  |   |                               | 13b. CITY   |   | 13c. CITY OR TOWN                    |                                |   |
| Maryland  |         |  |  |   |                               | Frederick   |   | Frederick                            |                                |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         |  |  |   |                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                           |   |                                      |                                |   |
| John F. Lewis   |         |  |  |   |                               | Juanita Laverne Ferguson  |   |                                      |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |                               | ADDRESS   |   |                                      |                                |   |
| Yes   |         | Vietnam  |  | 216-46-2900   |                               | Mr. John F. Lewis, 617 West Patrick St.<br>Frederick, Md. 21701         |   |                                      |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Shotgun wound of abdomen</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u><br><u>lying cause last.</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |  |  |   |                               |   |   |                                      |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |  |  |   |                               |   |   |                                      |                                |   |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                               |   |   |                                      |                                | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 2-19-87 19                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>self/inflicted   |                               |   |   |                                      |                                |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>bldg.                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>#3 Commerce Bldg. Frederick Co., Md.   |                               |   |   |                                      |                                |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |   |                               |   |   |                                      |                                |   |
| ACTUAL<br>SIGNATURE   |         | TITLE (SPECIFY)<br>M.D. Assistant  |  | MEDICAL EXAMINER  |                               |   | DATE<br>SIGNED 2-19-87                    |                                      |                                |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | 111 Penn Street  |  |   |                               |   |   |                                      |                                |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md. |   |                                      |                                |   |
| Burial  |         | Feb. 23, 1987  |  | Mount Olivet Cemetery   |                               |   |   |                                      |                                |   |
| 24. FUNERAL DIRECTOR'S<br>NAME  |         | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |                               | 25b. REGISTRAR'S SIGNATURE  |   |                                      |                                |   |
| Smith, Keeney & Basford Funeral Home  |         | 106 East Church Street, Frederick, Maryland  |  | FEB 25 1987   |                               | John Basford  |   |                                      |                                |   |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

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LEBSP GO for [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other circumstance, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |   | REG. NO. 05094  |  |
|--|--|---|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lloyd MARTIN Main</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 10 87</b>   |  |  |   | 2b. HOUR<br><b>3:57 PM</b>  |  |
| 3 SEX<br><b>M Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 8, 1924</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                             |  |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembly</b>             |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Factory</b> |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN<br><b>Frederick</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1205 Staley Avenue / 21701</b>  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Franklin Main</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Virginia Brandenburg</b>   |  |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Nellie Kemp Main, 1205 Staley Avenue, Frederick, Md. 21701</b>  |  |   |  |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY INTERSTITIAL FIBROSIS</b>   |  |   |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |  |  |  |   |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |  |   |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> 19 <b>87</b> , to <b>2/10</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/10</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>James S. Grissom M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/10/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James S. Grissom M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>1475 Taney Ave, Suite 204, Frederick, MD, 21701</b>   |  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 13, 1987</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>                  |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Smith, Keeney &amp; Bassford Funeral Home</b>   |  |   |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 17 1987</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James S. Grissom</b>  |   |   |  |
| 106 East Church Street, Frederick, Md. 21701   |  |   |  |  |  |   |  |  |   |   |  |

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Handwritten notes and stamps, including "1900" and "1901".

2/20/01 1901 1901 1901

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1901 1901 1901

Handwritten notes and stamps, including "1901" and "1902".

1901 1901 1901

044535 FEB 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing injury, or other traumatic event, the medical examiner must be notified once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05095

|  |  |  |  |   |   |  |   |  |   |  |
|--|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DONALD L. McCLEAF   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 / 11 / 87                     |   |   | 2b. HOUR<br>1330 M   |   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 12 10   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Transportation   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov.   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Frederick  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew L. McCleaf  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna McIntyre                  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NOT UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-03-4440 |   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Beatrice L. McCleaf, 209 Thomas Ave., Frederick, Maryland 21701   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>right cerebral infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____    |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>respiratory failure</u>  |  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2/7</u> , 19 <u>87</u> , to <u>2/11</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>John Vitarello MD</u>   |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2/11/87  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VITARELLO MD  |  |  | 22e. ADDRESS<br>335 Park Ave, Frederick, Md 21701                      |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Feb 11, 1987  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Resthaven Mem. Gardens                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick Frederick Md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>Smith Keeney Nasiford P. Funeral Home  |  |  |  |   | 25. FEB 17 1987   |  |   |  |   |  |
| 106 E. Church St., Frederick, Md. 21701  |  |  |  |   |   |  |   |  |   |  |

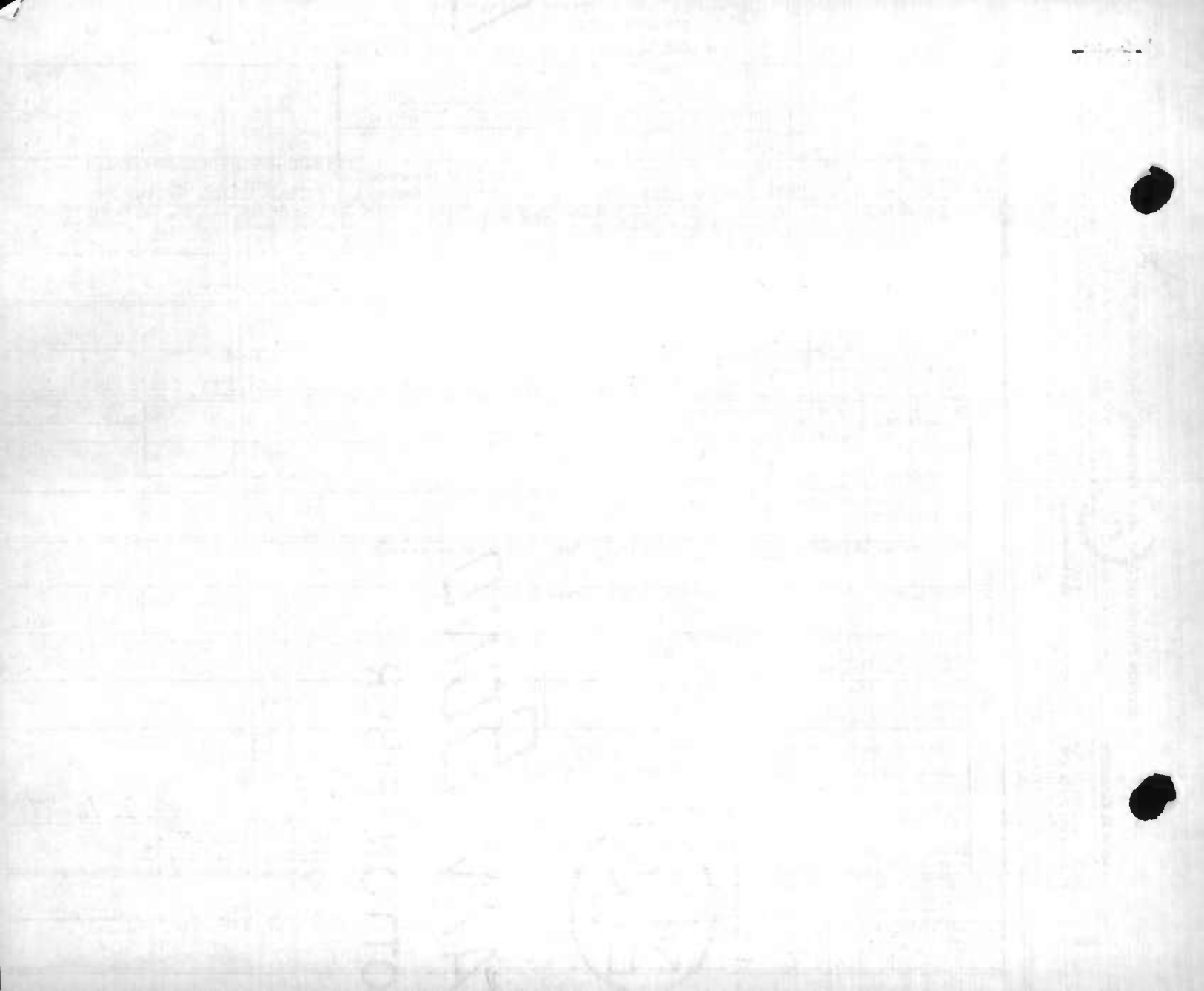
041711

04-2-0-1 FEB 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |   |   |   |   |  |   |  | REG. NO. 05090 |  |
|---|-------------------------|--|---|---|---|---|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELEANOR H. McCloskey</b>   |                         |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>02/15 1987</b> |  | 2b. HOUR <b>10:40</b>   |  |                |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Cauc.</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>May 24, 1920</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66 YRS.</b>           | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>02/15 1987</b>  |  | 2d. HOUR <b>11:00</b>   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, DC</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD.                                       |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1640 Andover Lane</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Defense Mapping Agency</b> |   |  |                |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET ADDRESS<br><b>1640 Andover Lane/21701</b>                               |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August W. Hagermann</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes M. Blackman</b>   |   |   |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>577-01-9151</b>              |   | 17. INFORMANT ADDRESS<br><b>Walter R. McCloskey, same as #13</b>              |   |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>CARDIOVASCULAR DISEASE</b>  |                         |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |   |   |   |   |  |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |   |   |   |  |   |  |                |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |   |  |   |  |                |  |
| ACTUAL SIGNATURE <i>John G. Ball</i>  |                         |  | TITLE (SPECIFY) <i>Deputy</i>                               |   | DATE SIGNED <i>2.16-87</i>  |   |  |   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>   |                         |  | ADDRESS <b>812 Toll House Ave. Frederick, Md. 21701</b>     |   |   |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                         |  | 23b. DATE <b>Feb. 19, 1987</b>                              |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>                 |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>           |  |                |  |
| 24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home, Rockville, Inc.</b>  |                         |  |   |   | 25. DATE REC'D. BY REGISTRAR <b>FEB 17 1987</b>                               |   | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>           |   |  |                |  |
| 300 West Montgomery Ave. Rockville, MD  |                         |  |   |   |   |   |  |   |  |                |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

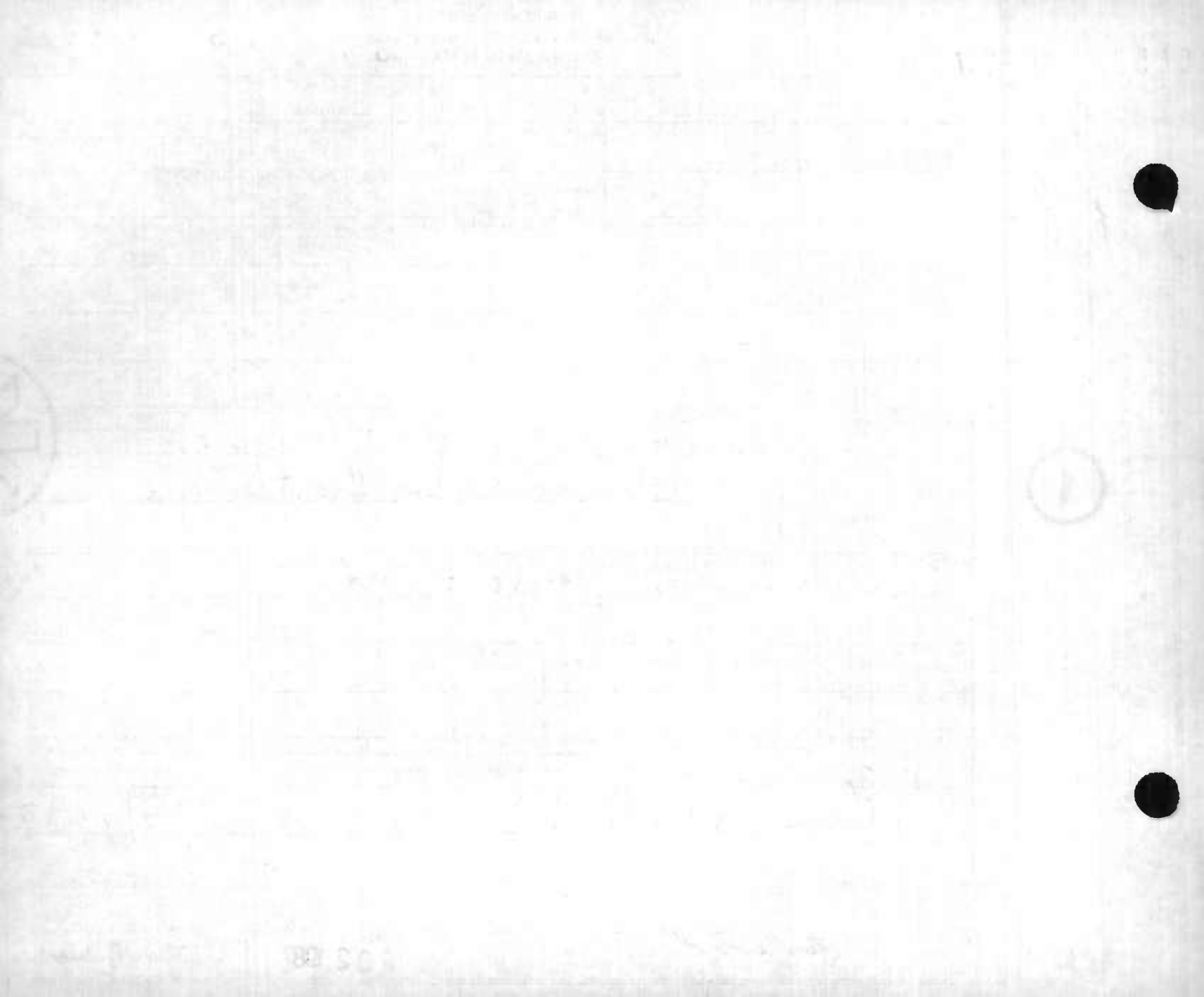
REG. NO.

|   |  |   |   |   |                                  |   |   |  |   |  |
|---|--|---|---|---|----------------------------------|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EDITH LENORA MERRITT  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 20, 1987          |   | 2b. HOUR<br>9:00 PM              |   |   |  |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 28, 1895   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS<br>91                               |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>FREDERICK, COUNTY MD.                 |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>ROCKY RIDGE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>9314 ROCKY RIDGE RD./21778 |   |   |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>NONE  |   |  |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>FREDERICK  |   | 13c. CITY OR TOWN<br>ROCKY RIDGE |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>9314 ROCKY RIDGE RD./ 21778 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN SIONS  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SIDNEY SHOEMAKER |   |                                  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>NONE   |   | 17. INFORMANT<br>JESSIE M. LISTON   |                                  | ADDRESS<br>9314 ROCKY RIDGE RD.<br>ROCKY RIDGE, MD. 21778                     |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Accident - old</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a |  |   |   |   |                                  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |   |   |                                  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Alan Carroll</u>   |  | DEGREE<br>M.D.  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                  |   |   | 22c. DATE SIGNED<br>2/23/87  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN L. CARROLL, M.D.  |  |   |   | 22e. ADDRESS<br>S. SETON AVE. EMMITSBURG MD. 21727  |                                  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/24/1987  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BLUE RIDGE CEMETERY   |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>THURMONT FREDERICK MARYLAND     |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT E. DAILEY & SON, P.A.  |  |   |   | ADDRESS<br>615 E. MAIN ST.<br>THURMONT, MD. 21788   |                                  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 02 1987                                  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Anderson-Kendall</u>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please submit this certificate to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



045832 MAR

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sister Eleanor Monaghan</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 22, 1987</b>                |   |  | 2b. HOUR<br><b>1:15 a.m.</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 19, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Emmitsburg</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa St. Michael, Emmitsburg, Md.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dgtrs. of Charit.</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Emmitsburg</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas B. Monaghan</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Cecilia Burke</b> |   |  | 13e. STREET ADDRESS<br><b>333 S. Seton Avenue 71727</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>234-01-8717J1</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>A Sr. Josephine-Villa St. Michael, Emmitsburg</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____ |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Recent Pneumonia</b>  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)      |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Alan Carroll</i> DEGREE <b>MD</b>  |  |  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>22 Feb 87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan Carroll, M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>S. Seton Ave. Emmitsburg, MD 21727</b>                        |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>24 Feb 87</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Emmitsburg, Frederick, MD</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Skiles Funeral Home, Emmitsburg, MD 21727</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1987</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7001 . 55 . 307

• 23:45

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• **CV**

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Villa St. Michael, Switzerland, 1909.

1975

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333 . 2 333

231-01-07741 - Dr. Josephine A. L. St. John, New York, New York

DATE: 11/11/11 TIME: 10:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |  |  |  |   |
|--|--|---|--|--|---|--|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Roland Hiner Myers   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>2/9/87                                 |  |   | 2b HOUR<br>0105 M  |  |  |   |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10 4 24   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.   |  |  |   |
| 10 CITY OR TOWN OF DEATH<br>Frederick  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>foreman   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>state hgw.   |   |
| 13a STATE<br>Maryland  |  |   | 13b COUNTY<br>Frederick  |  | 13c CITY OR TOWN<br>Libertytown   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin William Myers  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Vallie Pauline Hiner         |  |   | 13e STREET ADDRESS / ZIP CODE<br>9234 Oak Tree Circle/21762  |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W W II 220-16-0851 |  | 17 INFORMANT<br>Mary Myers 9234 Oak Tree Circle<br>Libertytown, MD            |  |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Terminal Malignancy - metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Primary Cancer of Mouth</u>                               |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>severe hypercalcemia - anemia due to cancer</u>   |  |   |  |  |   |  |  |  |   |
| 19a DATE OF OPERATION<br>0   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                         |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)            |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>2/8</u> 19 <u>87</u> to <u>2/9</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |  |  |   |
| 22b SIGNATURE<br><u>Nicholas P. Foris MD</u>   |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br>2/9/87  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>NICHOLAS P. FORIS MD   |  |   | 22e ADDRESS<br>27 W. 7. St. Frederick MD.                                    |  |   |  |  |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b DATE<br>2/12/87  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Resthaven Mem. Gardens                   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>nr. Frederick Frederick MD                        |  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>D. D. Hartzler & Sons   |  |   | ADDRESS<br>Libertytown, MD   |  |   | 25a DATE REC'D. BY REGISTRAR<br>FEB 11 1987  |  | 25b REGISTRAR'S SIGNATURE<br>Julia Decker-Lindner  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon duplicate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked on item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| DECEASED NAME<br>(TYPE OR PRINT) <b>Robert Lee Myrick</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/23/87</b>                                      |  | 2b. HOUR<br><b>0430 M</b>   |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 16, 1916</b>   |  | 6 AGE (IN YEARS, LAST BIRTHDAY)<br><b>70</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County MD.</b>                         |  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>System Annalist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electric Co.</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |   |  | 13b. COUNTY<br><b>Frederick</b>  | 13c. CITY OR TOWN<br><b>Frederick</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Arthur Myrick</b>   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susie Elizabeth Robison</b>            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>259-16-2860</b>  |  | 17 INFORMANT<br>ADDRESS <b>304 College Avenue</b><br><b>Jean R. Myrick, Frederick, Md. 21701</b> |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b>  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Idiopathic Dilated Cardiomyopathy</b>   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Unknown</b>   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ventricular tachycardia / fibrillation</b>   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2/17</b> , 19 <b>87</b> , to <b>2/22</b> , 19 <b>87</b> , that (1) (we) last saw the deceased alive on <b>2/22</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>John Vitarello MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>2/23/87</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John VITARELLO MD</b>  |  |  |  | 22e. ADDRESS<br><b>335 Park Ave, Frederick, Md 21701</b>                             |  |

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>Feb. 24, 1987</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Crematory</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Smithsburg, Wash. Md. 21783</b> |
| 24 FUNERAL DIRECTOR<br>NAME <b>Smith, Keeney &amp; Basford Funeral Home</b><br>ADDRESS <b>106 East Church Street, Frederick, Md. 21701</b> |                                   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1987</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Julia Gordon-Randall</b> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  |
| II DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Virginia Groff Routzahn  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb. 5, 1987 |   |  | 2b. HOUR<br>12:20 A.M.   |  |
| 3 SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 10, 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>teacher                        |  | 12b. KIND OF BUSINESS OR<br>Public schools   |  |
| 13a. STATE Md.  |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Middletown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>409 E. Main St. 21769  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Joseph Groff   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Henrietta Seitzinger  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>212-10-8228   |  | 17. INFORMANT ADDRESS<br>John T. Routzahn Middletown, Md.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Septic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Intra abdominal catastrophe</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Coronary artery disease</u>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/3/87</u> , 19____, to <u>2/5/87</u> , 19____, that (I) (we) last saw the deceased alive on <u>2/4/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Austin Barry</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>2/5/87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. A. A. Pearre Jr.   |  |   |  | 22e. ADDRESS<br>Frederick, Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Feb. 7, 1987   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lutheran Cemetery   |  | 23d. LOCATION<br>Middletown Fred. Md. STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Thompson Funeral Home Middletown, Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1987  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John T. Routzahn</u>   |  |  |  |

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Thompson General Motors, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(PAGE 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE REGISTRAR  
HOWARD A.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HOWARD A. SALTER   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 24, 1987   |  | 2b. HOUR<br>7:20 A.M.   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 9, 1906   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>INDIANA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. CITY OR TOWN OF DEATH<br>FREDERICK   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERIDIAN NURSING CENTER |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>FREDERICK MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MECHANIC  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SHEET METAL   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   |  | 13b. COUNTY<br>MONT.   |  | 13c. CITY OR TOWN<br>GAITHERSBURG   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>412 E. Diamond Ave. 20877  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>W. ARTHUR SALTER  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ORLA - WHEELER  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>267-09-8025   |  | 17. INFORMANT<br>AD 2033<br>SHIRLEY S. CHITTENDEN IJAMSVILLE, MD. 21754   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____                          |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alzheimer's disease, chronic anemia</u>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/10</u> , 19 <u>86</u> , to <u>2/24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><u>George L. Smith Jr.</u>  |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>2/24/87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. GEORGE SMITH, JR.  |  | 22e. ADDRESS<br>Frederick, Md. 21701   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>FEB. 27, 1987   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKLAWN CEMETERY   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROCKVILLE MONT. MD.   |  | 24. FUNERAL DIRECTOR<br>MURIEL H. BARBER LAYTONSVILLE, MD. 20879   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br>FEB 26 1987  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |                               |  |
|--|---|---|---|-------------------------------|--|
| 1- FOR STATE REGISTRAR   |   | 2a DATE OF DEATH  |   | 2b HOUR                       |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |   | 2a DATE OF DEATH  |   | 2b HOUR                       |  |
| EDITH PEARL WATKINS SCHADE   |   | February 14, 1987   |   | 2:00am                        |  |
| 3 SEX  | 4 RACE  | 5 DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)                                      | 7 IF UNDER 1 YEAR             |  |
| Female   | Caucasian   | February 8, 1911  | 76  | MONTHS DAYS HOURS MIN.        |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 9b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>     | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                               |  |
| Maryland   | U.S.A.  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Frederick, MD   |                               |  |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  | 12b KIND OF BUSINESS OR INDUSTRY                                    |                               |  |
| Frederick  | 34 East Patrick Street  | Ret. City Emp.  | None  |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |                               |  |
| 13a STATE  | 13b COUNTY  | 13c CITY OR TOWN  | 13d INSIDE CITY LIMITS?   | 13e STREET ADDRESS / ZIP CODE |  |
| Maryland   | Frederick   | Frederick   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 34 East Patrick St./21701     |  |
| 14 FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |   |                               |  |
| Vernon T. Watkins  |   | Edith P. Mount  |   |                               |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |   |                               |  |
| No   | 217-10-9328   | Mr. William E. Schade, Jr. Frederick, Md. 21701                               |   |                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |   |   |   |                               |  |
| PART I. DEATH WAS CAUSED BY:   |   |   |   |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE   |   |   |   |                               | YEARS  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |                               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |   |   |   |                               |  |
| b) MITRAL REGURGITATION  |   |   |   |                               | YEARS  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |                               |  |
| c) CORONARY ARTERY DISEASE   |   |   |   |                               | YEARS  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |   |                               |  |
| HYPERTENSION, PERIPHERAL VASCULAR DISEASE  |   |   |   |                               |  |
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a AUTOPSY?  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |                               |  |
|  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |   |                               |  |
|  | HOUR A.M. MONTH DAY YEAR P.M. 19  |   |   |                               |  |
| 21d INJURY OCCURRED  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f LOCATION  |   |                               |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | STREET CITY OR TOWN COUNTY STATE  |   |                               |  |
| 22a I certify that (I) (this hospital) attended the deceased from 19 81, to 2-14, 19 87, that (I) (we) last saw the deceased alive on 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |                               |  |
| 22b SIGNATURE  | DEGREE  |   |   | 22c DATE SIGNED               |  |
| Sherman Kahan  | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 2-14-1987                     |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e ADDRESS   |   |   |                               |  |
| Sherman Kahan, M.D.  | 4 West 7th Street Frederick, Md. 21701  |   |   |                               |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b DATE  | 23c NAME OF CEMETERY OR CREMATORY   | 23d LOCATION  |                               |  |
| Burial   | 2-18-1987   | Mt. Olivet Cemetery   | Frederick, Frederick, Maryland                                      |                               |  |
| 24 FUNERAL DIRECTOR  |   | 25a DATE REC'D. BY REGISTRAR  | 25b REGISTRAR'S SIGNATURE   |                               |  |
| R.E. DAILEY & SON, PA. 1201 N. Market Street Frederick, Md. 21701  |   | FEB 20 1987   | Julia Schade  |                               |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 05104

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Albert Scheel, Sr.                            |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 20, 1987  |  | 2b. HOUR<br>2:07 P.M.  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 8, 1916   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer                      | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Carroll   | 13c. CITY OR TOWN<br>Mt. Airy   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>206 Frederick Ave. 21771 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George H. Scheel                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Olive W. Nicholson   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-14-6715   | 17. INFORMANT<br>ADDRESS<br>Charles Robert Scheel, Mt. Airy, Md. 21771  |   |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 years</u> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diabetes mellitus</u>  |  | <u>5 years</u>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (the physician) attended the deceased from <u>7/16</u> , 19 <u>85</u> , to <u>2/20</u> , 19 <u>87</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>James P. Kerr M.D.</u>   | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>Feb. 21, 1987   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James P. Kerr, M.D.  |  | 22e. ADDRESS<br>26618 Ridge Rd., Damascus, Md. 20872   |   |

|  |                            |  |  |
|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                             | 23b. DATE<br>Feb. 23, 1987 | 23c. NAME OF CEMETERY OR CREMATORY<br>Pine Grove | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Mt. Airy, Carroll, Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Olin L. Molesworth, P.A., ADDRESS<br>Damascus, Md. |                            |  | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 24 1987                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove all other pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |   |   |   |   |
|--|-------------------------|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Maurice Joseph Schroyer</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><input checked="" type="checkbox"/> 2 16 19 87 |   | 2b. HOUR<br>M<br>7:40A  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Apr. 10 1908</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>78 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 16 19 87</b>                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Middletown</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>rear of 8836A Hollow Rd.</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD</b>   |   |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>3a. STATE<br><b>Maryland</b>  |                         |   | 13b. COUNTY<br><b>Frederick</b>   |   | 13c. CITY OR TOWN<br><b>Middletown</b>  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                         |   | 13e. STREET ADDRESS<br><b>8836A Hollow Road/21769</b>                                       |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thaddeus Hott Schroyer</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Oda Catherine Schroyer</b>              |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>212-38-9376</b>  |   | 17. INFORMANT<br><b>Gene Delauter</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease and Drowning</b><br>7108<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |   |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 2 16 19 87</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject collapsed into water</b>  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>stream</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>rear of 8836A Hollow Rd, Middletown, Fred, MD.</b>  |   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion          |                         |   |   |   |   |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |   | DATE SIGNED<br><b>2/17/87</b>   |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St. Balto. MD.</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |                         | 23b. DATE<br><b>Feb. 19, 1987</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion U. Methodist Cemt.</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Myersville Frederick Maryland</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1987</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |

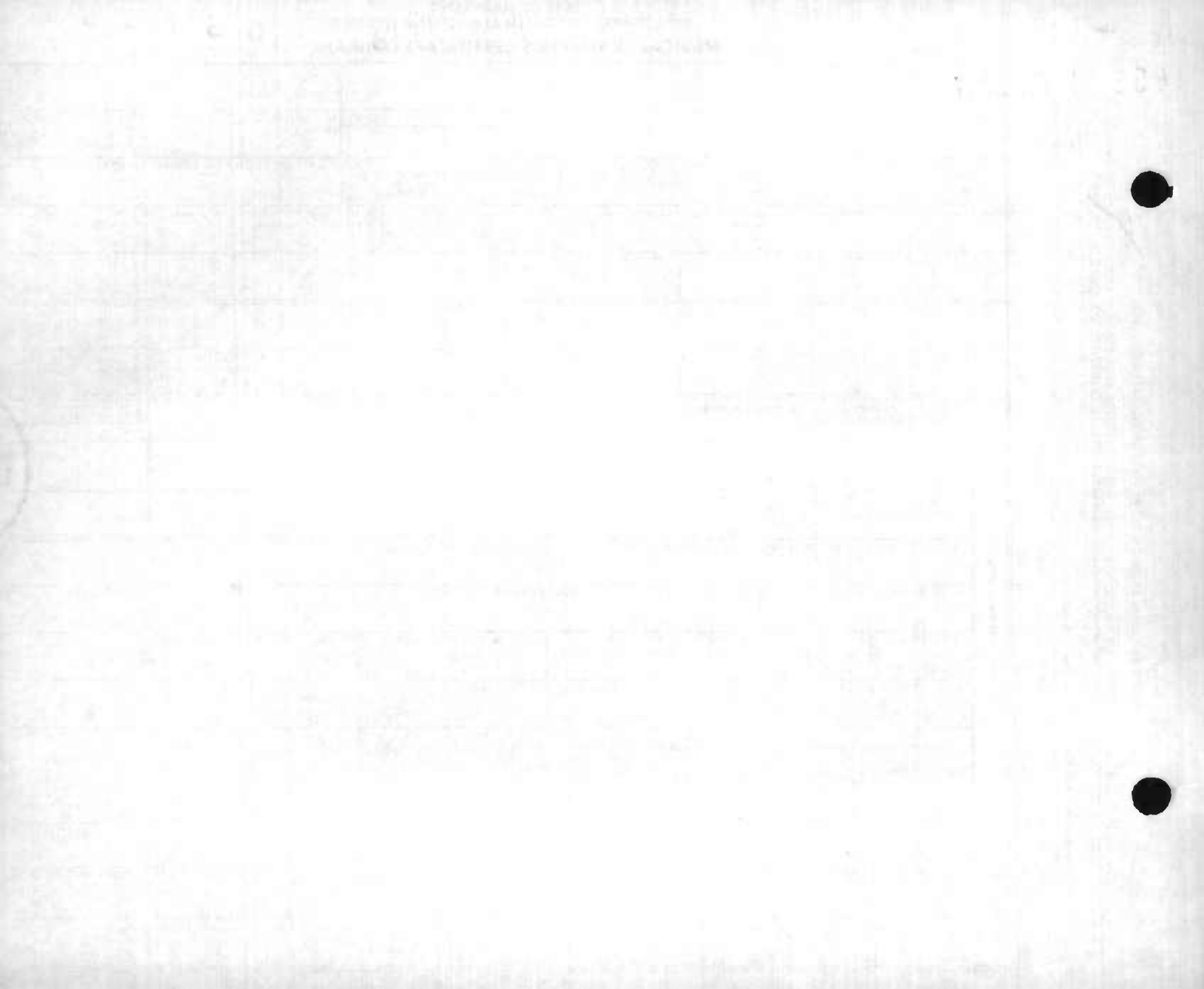
MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  | REG. NO. 05106  |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Adrian Leo Smith   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb. 14, 1987  |   | 2b. HOUR P. M.<br>9:30 P. M.                                  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 12, 1929  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 72 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky   | 7b. CITIZEN OF WHAT COUNTRY? (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick co. MD.  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Frederick  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>systems analyst   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>computers                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Frederick 13c. CITY OR TOWN Middletown   |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 4514 Willow Tree Dr. 21769 |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Demie George Smith   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lula Kathern Lewis  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>1948-1952   |  | 17. INFORMANT ADDRESS<br>Nancy V. Smith Middletown, Md.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) GI bleeding<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ca colon |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from many years 19 to 2/14/87 19, that (I) (we) lost saw the deceased alive on second week 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |   |
| 22b. SIGNATURE<br>Austin Pearre Jr.   |   | DEGREE  |  | 22c. DATE SIGNED<br>2/14/87   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Austin Pearre Jr.  |   | 22e. ADDRESS<br>Frederick, Md. 21701  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |   | 23b. DATE<br>Feb. 16, 1987  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Smithsburg Crematory  |   |
| 24. FUNERAL DIRECTOR NAME<br>Thompson Funeral Home  |   | 24b. ADDRESS<br>Middletown, Md.   |  | 25a. DATE OF C.D. BY REGISTRAR<br>FEB 20 1987   |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |   |

*[Faint, illegible handwriting on lined paper]*

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05107

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ethel<br/>ETHEL</b>                           |  | MIDDLE<br><b>Nichols</b>  |  | LAST<br><b>SMITH</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 2, 1987</b>                                     |  | 2b. HOUR<br><b>6:15 P.M.</b>                                  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 23, 1915</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Church</b>            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>529 Lee Place 21701</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Albert O. Nichols</b>                         |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bessie E. Coleman</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  | 17. INFORMANT <b>George K. Smith</b> ADDRESS <b>529 Lee Place Frederick, Md. 21701</b>  |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIOGENIC SHOCK - Cong HEART**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**COUMADIN RELATED SKIN NECROSIS**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>12/31/86</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>SKIN NECROSIS - DEBRIDEMENT</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>AUGUST 19 86</b> to <b>FEBRUARY 19 87</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 2 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>George I. Smith, Jr.</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>FEB. 2, 1987</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George I. Smith, Jr. MD</b>  |  |  |  | 22e. ADDRESS<br><b>804 Toll House Ave., Frederick, Md. 21701</b>   |  |  |  |

|   |  |                                  |  |  |  |  |  |
|---|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 5, 1987</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b> |  |
| 24. FUNERAL DIRECTOR <b>Smith, Keeney &amp; Basford Funeral Home</b><br>106 East Church St., Frederick, Md. 21701 |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>FEB 09 1987</b>                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This please remove carbon papers. Pages 1 and 2 should be filed with the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified of the death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

05100

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Warren Smith   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 20 87 |   |  | 2b. HOUR<br>10 P.M.  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 3 1917  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Mt. Carmel, Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Fred   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Fred. Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manger           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Stereo   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.   |  | 13b. COUNTY<br>Fred  |  | 13c. CITY OR TOWN<br>Knoxville, Md.   |  | 13d. STREET ADDRESS / ZIP CODE<br>620 Knoxville Rd. Knox, Md. 21758                  |  |   |  |
| 14. FATHER'S NAME<br>William Watkins  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Margaret Eona Lewis   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes Army  |  |  |  | 16b. SOCIAL SECURITY NO.<br>166-14-4021   |  | 17. INFORMANT<br>Ardella E. Smith wife   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary Artery Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4-6 hours<br>years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Cancer of Colon  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>2/19/87   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Revision of colostomy  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19/87 to 2/20/87 that (I) (we) last saw the deceased alive on 2/20/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Casper E. Cline Jr MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>2/23/87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Casper E. Cline Jr   |  |  |  | 22e. ADDRESS<br>804 Toll House Ave  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>2/22/87   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Smithsburg, Md.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Smithsburg Wash. Md.                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John T. Williams  |  |  |  | ADDRESS<br>100 Petersville Rd. Smithsburg, Md.  |  | 25a. DATE REC'D BY REGISTRAR<br>FEB 26 1987  |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lafayette N. SPECHT</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 10, 1987</b>  |  | 2b. HOUR<br><b>3 A. M.</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 19, 1908</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Citizens Nursing Home of Fred. Co.</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Buffer and Polisher-Foundry</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Frederick</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Clyde Specht</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Isabelle Linton</b>                           |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>211-10-3612</b>   |  | 17. INFORMANT<br><b>Richard L. Gladhill,</b>   |  | ADDRESS<br><b>6009 Sunny Brook Drive<br/>Frederick, Md. 21701</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 hr</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterio-sclerotic C.V.D.</b>  |  |  |  |   | <b>5y</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebral Thrombosis with hemiparesis</b>  |  |  |  |   | <b>10y</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic Schizophrenia</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1965</b> to <b>Feb 10, 1987</b> that (I) <del>was</del> last saw the deceased alive on <b>Feb. 9, 1987</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Bernard O. Thomas, Jr. M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>2/11/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Bernard O. Thomas, Jr., M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>Professional Building, Frederick, Md. 21701</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 12, 1987</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven Memorial Gardens Frederick, Frederick, Md</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Smith, Keeney and Basford Funeral Home</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1987</b>   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place this certificate in the papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |   |  |   |  |
|--|--|---|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 05110  |   | 87   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Edwin ELLSWORTH Spurger</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <i>5 Feb 8, 87</i> |  |  | 2b. HOUR <i>11:21</i> M   |  |   |  |
| 3. SEX <i>MALE</i>   |  | 4. RACE <i>WHITE</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR <i>09 03 1915</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>FREDERICK</i> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <i>FREDERICK</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FREDERICK MEMORIAL HOSPITAL</i> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LABORER</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>FARM</i> |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |  |   |  |   |  |
| 13a. STATE <i>MD</i>   |  | 13b. COUNTY <i>FREDERICK</i>  |   | 13c. CITY OR TOWN <i>FREDERICK</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>WILLIAM SPRINGER</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MINERVA WILHIDE</i>   |   | 13e. STREET ADDRESS / ZIP CODE <i>1407 rinewood Drive, 21701</i>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>  |  | 16b. SOCIAL SECURITY NO. <i>N/A</i>   |   | 17. INFORMANT ADDRESS <i>Thurmont, MD</i>  |  |   |  |   |  |
| 16c. <i>NO</i>   |  | 16d. <i>N/A</i>   |   | 17a. <i>Clara Green 8161A Rocky Ridge Rd.,</i>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest, 7 myocardial infarct 5 minutes</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis from pneumonia, accompanied by disease.</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial infarction 2nd from multiple infarct.</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Chronic disease</i> |  |   |   |  |  |   |  |   |  |
| 19. DATE OF OPERATION  |  | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8 Feb 1987</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>8 Feb 1987</i> to <i>8 Feb 1987</i> , that (I) <i>viewed</i> the deceased alive on <i>8 Feb 1987</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>viewed</i> the body after death.  |  |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE <i>Galen F. Brooks, M.D.</i>  |  | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Galen F. Brooks, M.D.</i>   |  | 22e. ADDRESS <i>4 Kent 7th St SE</i>  |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>  |  | 23b. DATE <i>2/12/87</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY <i>Graceham Moravian Cem</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Graceham Frederick MD</i>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <i>G. DOUGLAS STAUFFER</i>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR <i>FEB 24 1987</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>  |  |   |  |
| 1621 Opossumtown Pike, Frederick, MD 21701   |  |   |   |  |  |   |  |   |  |

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FEB 24 1987  
John Deere

46154 MAR-87

#18a, Part 2, & 22a, G-625  
 1- STATE Med. Ex., 3/26/87  
 REGISTRAR Gbi  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05111  
 REG. NO.

|  |         |  |  |   |  |   |  |  |  |  |  |
|--|---------|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Joshua Robert Earl Stepper   |         |  |  |   |  |   |  | 2-27 19 87                                 |  | a. M   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)  |  | IF UNDER 24 YRS.<br>MONTHS DAYS HOURS MIN                     |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR |  | 7d. HOUR                                     |  |
| Male   | White   | 6 27 1977  |  | 9 YRS.  |  |   |  | 2-27 19 87                                 |  | 10:15 a. M                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |  |  |  |
| Oregon   |         | U. S. A.   |  |   |  | Frederick County, MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY          |  |  |  |
| Frederick  |         | 10304 Putman Road  |  |   |  | Student   |  | Education                                  |  |  |  |
| USUAL RESIDENCE (IF IN THIS STATE, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |  |  |   |  |   |  |  |  |  |  |
| 13a. STATE   |         | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS   |  |  |  |  |  |
| Washington   |         | Chelan   |  | Wenatchee   |  | 98801<br>1301 Ninth Street 99999                              |  |  |  |  |  |
| FATHER'S NAME<br>FIRST MIDDLE LAST   |         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |  |  |
| Eric Stepper   |         |  |  | Laura Vickery   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |   |  |  |  |  |  |
| NO   |         | 534-96-3858  |  | Eric Stepper 1301 Ninth Street Wenatchee, Washington 98801  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Laryngo-Tracheobronchitis and Bronchopneumonia.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a<br><u>Hyperkinetic disruptive syndrome</u>   |         |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  |  |  |
|  |         |  |  |   |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |
|  |         |  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
|  |         |  |  |   |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)<br>Deputy Chief  |  |   |  |   |  | DATE SIGNED 2-28-87                        |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |  |  |  |  |
| Ann M. Dixon, M.D.   |         | 111 Penn St., Balto., Md. 21201  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                    |  |  |  |  |  |
| Cremation  |         | 3-3-87   |  | Jones & Jones Crematory   |  | Wenatchee, Chelan, Washington                                 |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                 |  | 25b. REGISTRAR'S SIGNATURE                 |  |  |  |
| Marzullo Funeral Service Upperco, MD.  |         |  |  |   |  | MAR 04 1987   |  | Julia Twicken-Parker                       |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, CREMATION, REMOVAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

UNITED STATES

NAVY



— 7125-A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Harry Roland Stillions, Sr.</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2-6-87</i>  |  | 2b. HOUR<br>MIN.<br><i>11:55 P.M.</i>   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>July 17, 1922</i>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>64</i> YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 8. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Frederick County</i> MD.                                |  |
| 12. CITY OR TOWN OF DEATH<br><i>Frederick</i>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Frederick Memorial Hospital</i> |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Guard Army Map Service</i>    |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><i>Maryland</i>  |  | 15b. COUNTY<br><i>Frederick</i>   |  | 15c. CITY OR TOWN<br><i>Frederick</i>   |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John H. Stillions</i>  |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mamie Smith</i>   |  | 18. STREET ADDRESS / ZIP CODE<br><i>5934 Bartonsville Rd., 21701</i>                                |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  | 20. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW II</i>  |  | 21. INFORMANT<br><i>Mrs. Ida F. Stillions</i><br><i>5934 Bartonsville Rd., Frederick, Md. 21701</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>(C) Pneumonia with sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>SEVERE END-STAGE COPD</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>CORONARY ARTERY DISEASE</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i> |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) <i>(the hospital)</i> attended the deceased from <i>12/25</i> 19 <i>85</i> , to <i>Feb 6</i> 19 <i>87</i> , that (I) <i>(was)</i> last saw the deceased alive on <i>Feb 6</i> 19 <i>87</i> , and that in (my) <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(did)</i> <i>(did not)</i> view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>James S. Grissom M.D.</i>  |  | DEGREE<br><i>M.D.</i>   |  | 22c. DATE SIGNED<br><i>2/6/87</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>James S. Grissom M.D.</i>   |  | 22e. ADDRESS<br><i>1475 Tany Ave. Suite 204 Frederick, Md. 21701</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>Feb. 10, 1987</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resthaven Mem. Gardens</i>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Frederick, Frederick, Md.</i>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Smith, Keeney &amp; Basford Funeral Home 106 East Church St., Frederick, Md. 21701</i>               |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 18 1987</i>   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Roadner</i>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-hour permit. Then please have copies of pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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045364

FEB 26 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05113

|   |                                     |   |   |   |   |
|---|-------------------------------------|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GRACE ELIZABETH STRIDE  |                                     |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/24/87  |   | 2b. HOUR<br>0342 M  |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUC.                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 07 1895  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Frederick   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.                                 |   |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital                    |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired/del. serv | 12b. KIND OF BUSINESS OR INDUSTRY<br>dry goods  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                                     |   |   |   |   |
| 13a. STATE<br>MD  | 13b. COUNTY<br>FREDERICK            | 13c. CITY OR TOWN<br>FREDERICK  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>257 WASHINGTON STREET, 21701                        |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN R. STOTTMAYER  |                                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SUSAN WOLFE                                    |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  | 17. INFORMANT<br>ADDRESS<br>Irvin Stride 908 Motter Ave., Frederick MD                          |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pulmonary edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>previous myocardial infarction</u>  |                                     |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NO</u>  |                                     |   |   |   |   |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> , 19 <u>87</u> , to <u>2/24</u> , 19 <u>87</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>2/23</u> , 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. |                                     |   |   |   |   |
| 22b. SIGNATURE<br><u>John A. Vitarello MD</u>   |                                     | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN A. VITARELLO MD   |                                     | 22e. ADDRESS<br>335 PARK AVE, Frederick, MD   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>2/27/87                | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick Frederick MD                  | 23e. DATE REC'D. BY REGISTRAR   |
| 24. FUNERAL DIRECTOR<br>NAME G. DOUGLAS STAUFFER<br>ADDRESS Frederick, MD<br>Stauffer's 1621 Opossumtown Pk.  |                                     |   |   | 25a. REGISTRAR'S SIGNATURE  |   |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted and

FEB 24 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

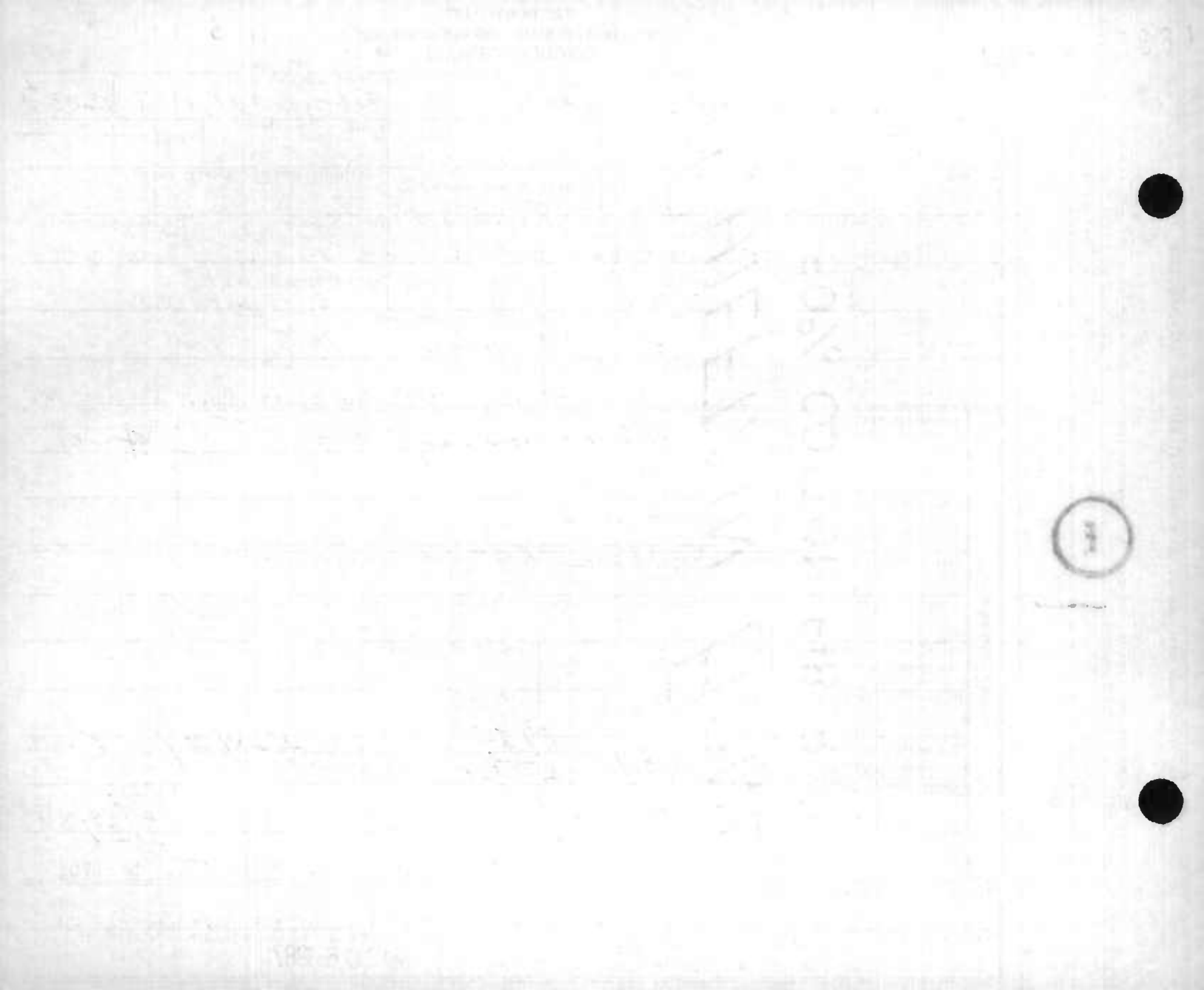
TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This certificate requires carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Daisy Lee Stull</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 28, 1987</b>  |  | 2b. HOUR<br>A M<br><b>0603</b>  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 21 1907</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>00 00</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>FREDERICK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FREDERICK MEMORIAL HOSPITAL</b>             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF-EMPL.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ANTIQUES</b>   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>602 Biggs Ave., 21701</b>  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>FREDERICK</b>  |  | 13c. CITY OR TOWN<br><b>FREDERICK</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT<br><b>Emory Stull</b>  |  | ADDRESS<br><b>602 Biggs Ave., Frederick, MD</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>4 mos</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 mos</b> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>2/28/87</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Adenocarcinoma of lung</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19 2/28/87</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>804 Tollhouse Ave., Frederick, MD 21701</b>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert L. Kaufmann, MD</b>   |  | 22c. DATE SIGNED<br><b>2/28/87</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT KAUFMANN</b>   |  |
| 22e. ADDRESS<br><b>804 Tollhouse Ave., Frederick, MD 21701</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   |  |
| 23b. DATE<br><b>3/3/87</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>G. DOUGLAS STAUFFER<br/>1621 Opossumtown Pike, Frederick, MD 21701</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 06 1987</b>  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Lia Gordon-Randall</b>   |  |  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Mary Elsie Thompson  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>02 24 87                          |   | 2b HOUR<br>5:55P M  |
| 3 SEX<br>F   | 4 RACE<br>B  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr 8 1908  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD                     |   |   |
| 10 CITY OR TOWN OF DEATH<br>Boonsboro, MD  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Reeder's Memorial Home |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook | 12b KIND OF BUSINESS OR INDUSTRY<br>Resturant                                       |   |
| 13a STATE<br>Md  |  |  | 13b COUNTY<br>Frederick   | 13c CITY OR TOWN<br>Centerville   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Henry Thompson   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ora Smith  |   |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>214 28 0690   |   | 17 INFORMANT<br>ADDRESS<br>Ruth E. Thompson Fingerboard Rd                          |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Auto CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD, CAID</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sudden</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.          |  |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>McHantel dementia</u>   |  |  |   |   |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Feb 24</u> , 19 <u>87</u> , to <u>Feb 24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) place the body after death. |  |  |   |   |   |
| 22b SIGNATURE<br><u>K.E. Hicks</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   | 22c DATE SIGNED<br><u>2/25/87</u>   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>K.E. Hicks</u>  |  | 22e ADDRESS<br><u>P.O. Box 246 / KEEPYVILLE, MO. 21752</u>   |   |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b DATE<br><u>Feb 28</u>  | 23c NAME OF CEMETERY OR CREMATORY<br><u>Ebenezer</u>                    |   | 23d LOCATION<br>CITY OR TOWN COUNTY<br><u>Ijamsville Frederick MD</u>   |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Burial C.E. Hicks, 111</u>   |  | ADDRESS<br><u>1922 Forest Drive</u>  |   | 25a DATE REC'D. BY REGISTRAR<br><u>FEB 27 1987</u>                                  | 25b REGISTRAR'S SIGNATURE<br><u>Julia Gordon-Rodgers</u>  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

05110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove contents of pages 1 and 2 and place them in the container provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Francis White, Sr  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 13 1987  |   | 2b HOUR<br>P.M.   |
| 3 SEX<br>Male  | 4 RACE<br>B  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>July 25 1901  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br>85   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   | 7b CITIZEN OF WHAT COUNTRY<br>U.S.A  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick, MD   |   |   |
| 10 CITY OR TOWN OF DEATH<br>Buckeystown  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6208 Manor Woods Rd |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Heavy Equip. op.            |   | 12b KIND OF BUSINESS OR INDUSTRY  |
| 13a STATE<br>MD  | 13b COUNTY<br>Frederick  | 13c CITY OR TOWN<br>Buckeystown  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br>6208 Manor Woods Rd 21717                          |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Francis White   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Eckert  |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b SOCIAL SECURITY NO.<br>217-10-9104   |  | 17 INFORMANT<br>ADDRESS<br>ANNAMAE Spriggs Monrovia MD                              |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA</u>   |  |  |  |   |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Jan 13 Feb 85</u> to <u>Feb 87</u> , that (we) last saw the deceased alive on <u>Feb 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |
| 22b SIGNATURE<br>Morris A. Wilkinson MD  |  | DEGREE<br>MD   |  | 22c DATE SIGNED<br>16 Feb 87  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Morris A. Wilkinson MD   |  | 22e ADDRESS<br>700 W Market St Frederick MD  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b DATE<br>Feb 18, 1987   | 23c NAME OF CEMETERY OR CREMATORY<br>Hopewell  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick MD                           |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>C.E. Hicks  |  | 24b ADDRESS<br>1922 Forest Drive   |  | 25a DATE REC'D BY REGISTRAR<br>FEB 19 1987  | 25b REGISTRAR'S SIGNATURE<br>Julia Davidson Rodell  |

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE REGISTRAR  |  |                      |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                            |  |  |  |  |  |  |  |   |  | REG. NO. 05111         |  |                   |  |
|--|--|----------------------|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|---|--|------------------------|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GAHLON BILLMAN WHITE</b>  |  |                      |  |   |  |  |  |   |  | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>24 4 87</b> |  |  |  |  |  |  |  |   |  | 2b. HOUR <b>6:00am</b> |  |                   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JAN. 22, 1916</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>71</b> YRS.                      |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>24 4 87</b>  |  |  |  |  |  |   |  |                        |  | 2d. HOUR <b>M</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDIANA</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK COUNTY</b>                                 |  |  |  |  |  |   |  |                        |  | MD.               |  |
| 10. CITY OR TOWN OF DEATH <b>THURMONT</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11126 HESSON BRIDGE RD. 21788</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>                                  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |   |  |                        |  |                   |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      |  | 13b. COUNTY <b>FREDERICK</b>  |  |  |  | 13c. CITY OR TOWN <b>THURMONT</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET ADDRESS <b>11126 HESSON BRIDGE RD. 21788</b> |  |   |  |                        |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>ROSCOE (NMI) WHITE</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>MAHALA (NMI) HARLOW</b> |  |   |  |   |  |  |  |  |  |  |  |   |  |                        |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>1941-1961</b>   |  |  |  | 17. INFORMANT <b>LUISE WHITE</b>  |  |   |  | 11126 HESSON BRIDGE RD. THURMONT, MD. 21788  |  |  |  |  |  |   |  |                        |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>9293 Atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |  |  |   |  |                        |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Carcinoma lung (post op); COPD; Frx. hip post op 1 year.</b>   |  |                      |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |                        |  |                   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |   |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                        |  |                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |  |  |   |  |                        |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |  |  |   |  |                        |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |                        |  |                   |  |
| ACTUAL SIGNATURE <b>Robert J. Thomas MD</b>  |  |                      |  | TITLE (SPECIFY) <b>Deputy</b>   |  |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>2/4/87</b>  |  |  |  |  |  |   |  |                        |  |                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Robert J. Thomas, M.D.</b>  |  |                      |  | ADDRESS <b>812 Toll House Ave. Frederick, Md. 21701</b>   |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |                        |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>2/7/1987</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>UTICA CEMETERY</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>UTICA FREDERICK MARYLAND</b>                   |  |  |  |  |  |   |  |                        |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>ROBERT E. DAILEY &amp; SON, P.A.</b>   |  |                      |  |   |  |  |  |   |  | ADDRESS <b>615 E. MAIN ST. THURMONT, MD. 21788</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 02 1987</b> |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Swenson-Rudolph</b>                             |  |                        |  |                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

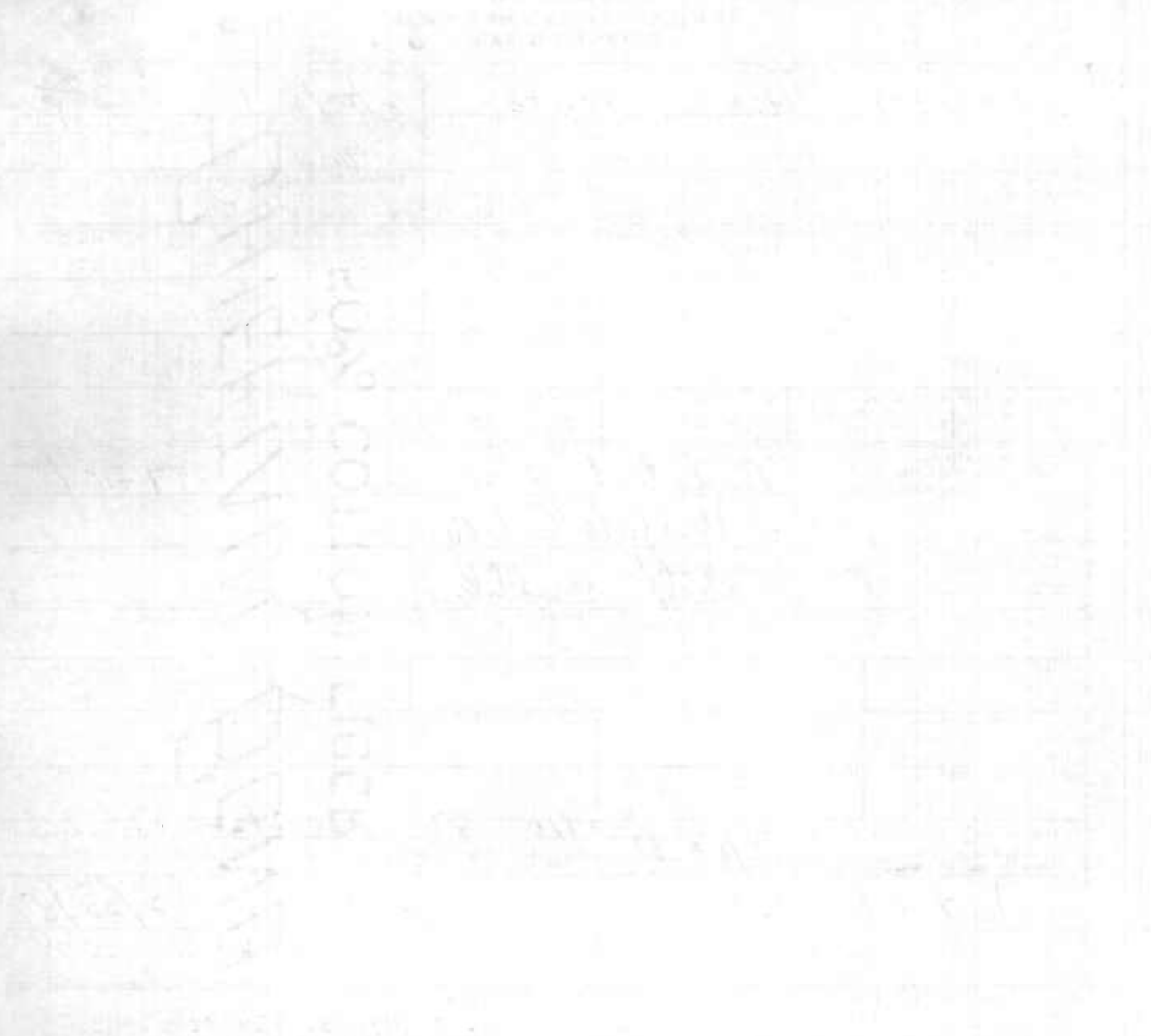
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as item 11 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>CHARLES Albert WOLFE</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2/20/87</b>   |  | 2b. HOUR MIN.<br><b>3:25 P.M.</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 10, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co. MD.</b>                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>welder</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>gov't.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Frederick</b>   |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8 Linden Ave. 21701</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Albert C. Wolfe</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ida Winfield</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>W. W. 11 214-10-1081</b>  |  | 17. INFORMANT<br><b>Ethel Wolfe</b>   |  | ADDRESS<br><b>Frederick, Md. 21701</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Reluctant pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>multib C. Uth.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic mellit</b>   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7-10 d</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>87</b> , to <b>2/22</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>2/23</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert R. Hughes</b>   |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>2/22/87</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Robert Hughes</b>   |  |  |  | 22e. ADDRESS<br><b>Frederick, Md. 21701</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 25, 1987</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Myersville Fred. Md.</b>                       |  |   |  |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS<br><b>Thompson Funeral Home Middletown, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jim [Signature]</b>   |  |   |  |

BP

FEB 27 1987



Thompson Primary School, No. 1

044337 FEB 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |   |  |   |  |
|---|--|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLIFFORD Matthew YINGER</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>4</b> YEAR <b>87</b> |   |  |   |  | 2b. HOUR<br><b>4:30 PM</b>                      |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>CAUC</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>17</b> YEAR <b>1893</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>FREDERICK MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK MD</b>                                     |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FREDERICK MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERIDIAN - FREDERICK</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>FREDERICK</b>  |  | 13c. CITY OR TOWN<br><b>FREDERICK</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>201 UPPER COLLEGE TERRACE</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>WILLIAM</b> MIDDLE <b>C.</b> LAST <b>YINGER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Valletta</b> MIDDLE <b>BENDER</b> LAST <b>BENDER</b>   |   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-10-9297</b>  |  |  |  | 17. INFORMANT<br><b>Mr. David H. Yinger, Jr.</b>  |   |   |  | ADDRESS <b>146 W. Patrick St. Frederick, Md. 21701</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic heart dis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>arrhythmia</b>   |  |  |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 17</b> , 19 <b>53</b> , to <b>Feb 4</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>Jan 6</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Thomas E. Stone</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |   |  | 22c. DATE SIGNED<br><b>2-6-87</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas E. Stone</b>   |  | 22e. ADDRESS<br><b>4 West 5th St Frederick, Md</b>   |  |   |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/7/87</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>R. E. Dailey &amp; Son, B. A.</b> ADDRESS <b>1201 N. Market St. Frederick, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 13 1987</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>W. Gordon Pender</b>   |   |   |  |   |  |   |  |

11/11/11